

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/transt permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1 - STATE REGISTRAR

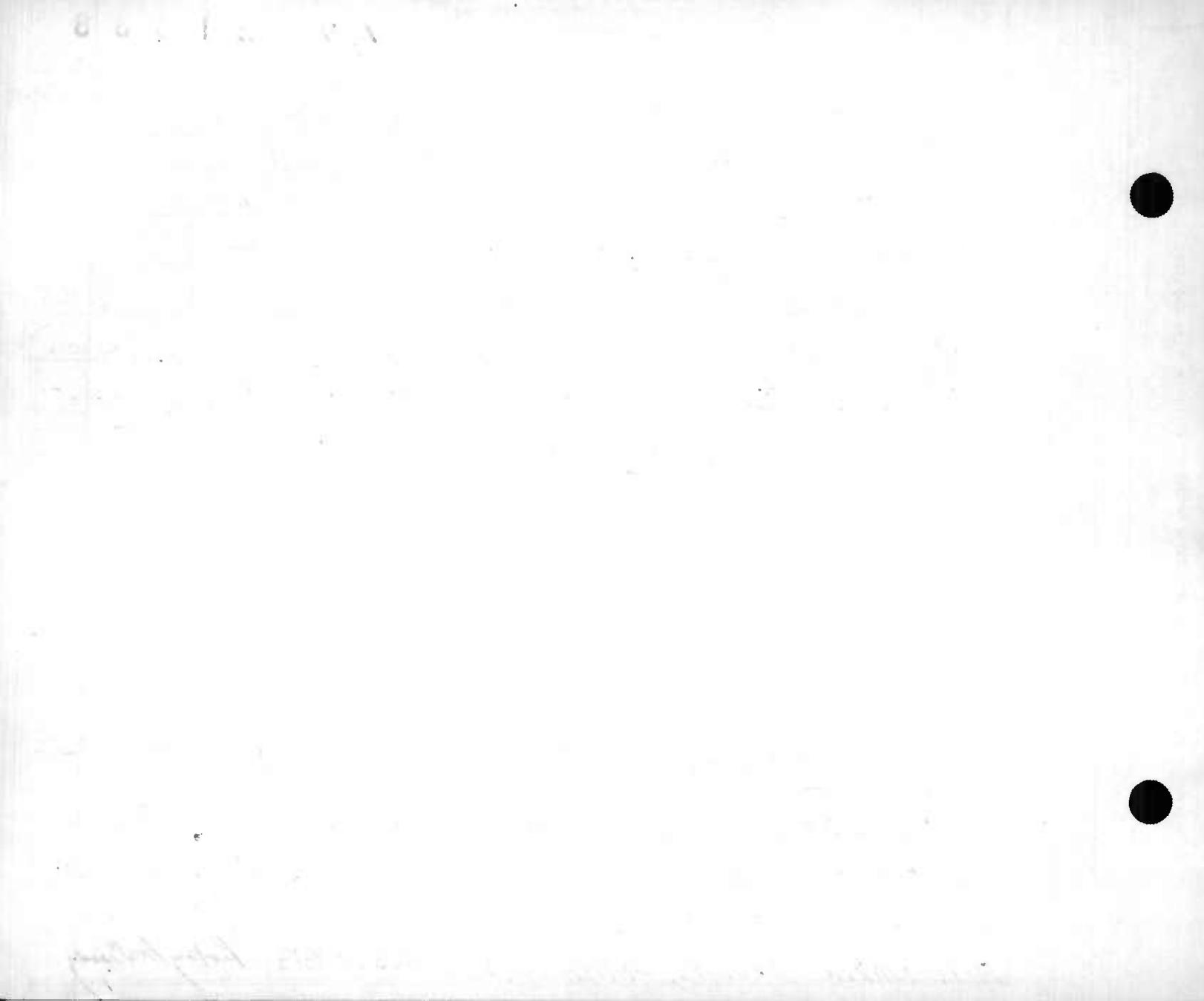
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

9 2 1 0 3 8

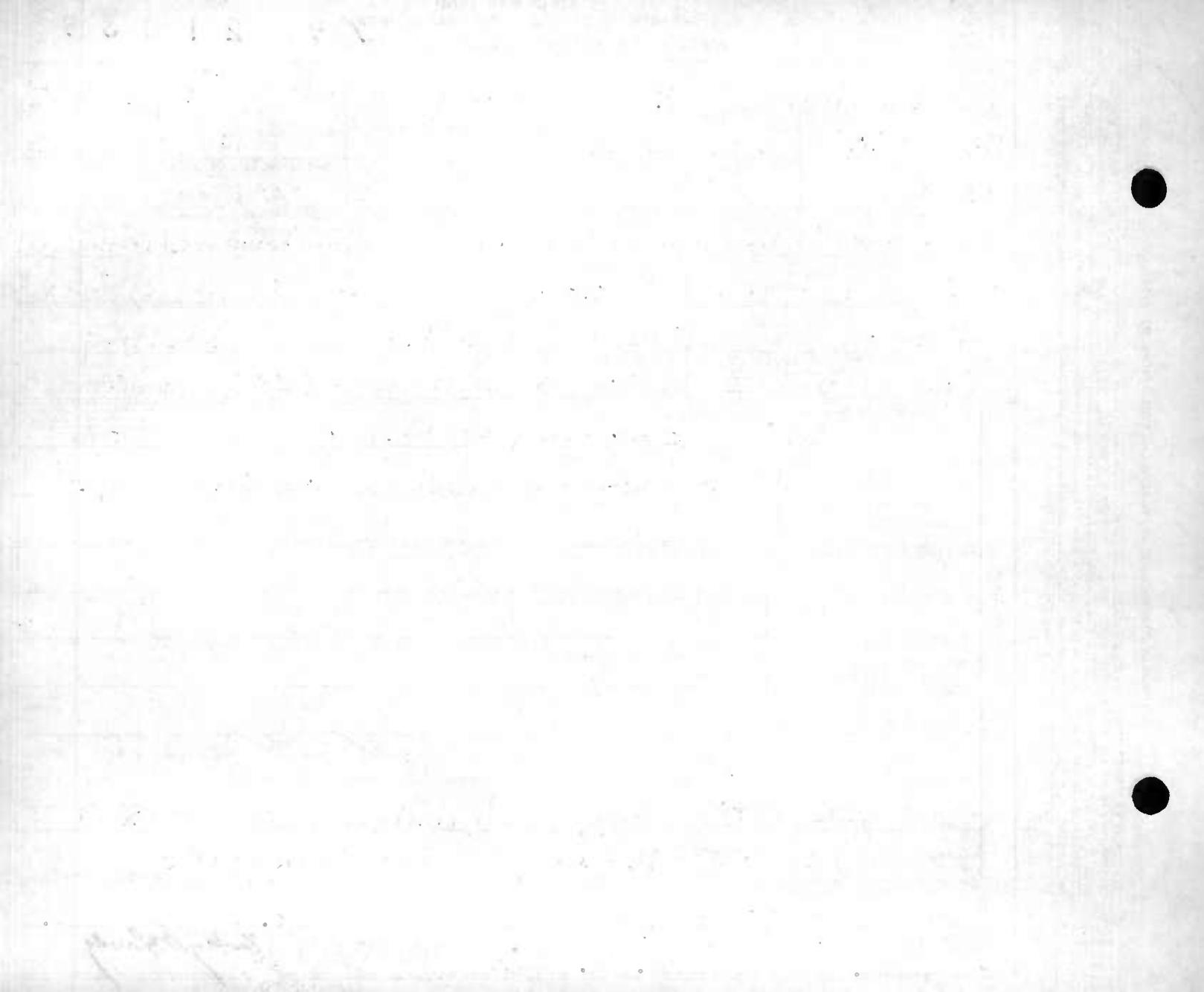
| | | | | | | | | | | | | |
|--|--|--|--|--|------|---|--|-------------|---|-----------------------------------|---------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | | |
| <i>Benjamin Charles Adams</i> | | | | | | <i>Aug. 24, 1979</i> | | | | <i>2:15 PM</i> | | |
| 3. SEX | | | 4 RACE | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR MONTHS DAYS | 8. IF UNDER 24 HRS HOURS MIN | |
| <i>Male</i> | | | <i>Caucasian</i> | MONTH | DAY | YEAR | <i>64</i> | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| <i>Wisconsin WI</i> | | | <i>USA</i> | | | | | | <i>Wisconsin</i> | | | |
| CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| <i>Salisbury</i> | | | <i>Dykes Rd. Rt #9</i> | | | <i>florist</i> | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS | | | |
| <i>Md.</i> | | | <i>Wisconsin</i> | | | | | | <i>Dykes Rd. Rt #9</i> | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| <i>John W. Atkins</i> | | | <i>Bertha</i> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | |
| <i>Yes WWII</i> | | | <i>217-30-7945</i> | | | <i>EMMA Lee Atkins Sane</i> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PARTY DEATH WAS CAUSED BY | | | IMMEDIATE CAUSE (a) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| <i>lung cancer</i> | | | | | | | | | | | | |
| 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost | | | DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | |
| | | | DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | |
| 22a. I certify that (I) the hospital attended the deceased from <i>8/24/79</i> , 1979, to <i>8/24</i> , 1979, that (I) was lost saw the deceased alive on <i>8/24/79</i> , 1979, and that in (my) my opinion death occurred on the date and hour and from the causes stated above. (I) did not view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Grasso</i> | | DEGREE <i>MD</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>8/24/79</i> | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joseph A. Grasso</i> | | 22e. ADDRESS <i>Peninsula Gov. Hosp. Salisbury Md.</i> | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (IF ANY) | | 23b. DATE <i>8/27/1979</i> | | 23c. NAME OF CEMETERY OR CREMATORIUM <i>Arco Mem. Park</i> | | 23d. LOCATION CITY OR TOWN <i>Salisbury Md.</i> | | 23e. COUNTY | | | 23f. STATE | |
| 24. FUNERAL DIRECTOR NAME <i>Hill-Baker-Bounds, Salisbury Md.</i> | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR <i>AUG 28 1979</i> | | | 25b. REGISTRAR'S SIGNATURE <i>Hilary McElroy</i> | | | | | |

BP _____



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 21039 | | | | |
|---|--|--|--|------------------------------------|---|---|------|--------------------------------------|---|---|--------------------------------|---|-------|-------------------------|--|--|
| 1- FOR STATE REGISTRAR | | I. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | | | 2a. DATE KNOWN OF DEATH ESTI- MATED | MONTH | DAY | YEAR | 2b. HOUR 120 P.M. | | |
| | | William | | | H | Airey, S. R. | | | | <input checked="" type="checkbox"/> | Aug 18 | 1979 | | 120 P.M. | | |
| 3. SEX | | 4 RACE | 5 DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR MONTHS DAYS | | | IF UNDER 24 HRS HOURS MIN | | | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR 120 P.M. | | |
| Male | | W | 3 12 22 | 57 yrs. | | | | | | | Aug 18 1979 | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | Wicomico | | | | | |
| Baltimore | | USA | | | <input checked="" type="checkbox"/> | | | | | | MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING-LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | Maintenance Beth. Steel | | | | | |
| Salisbury | | Peninsula General | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS | | | Pftz Box 539-25 GLEN ARI | | | | |
| Md | | Baltimore | | Glen Arm | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | Pftz Box 539-25 GLEN ARI | | | | | | | |
| 14. FATHER'S NAME | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | | FIRST | MIDDLE | LAST | Stalling | | | | | |
| Albert | | | | Airey | Sally | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | | | | | |
| Yes w w II | | 215-16-1760 | | | Nellie Airey (wife) same address | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| IMMEDIATE CAUSE (a) coronary occlusion 410- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | min | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | 4 yrs | | | | |
| (c) | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | 20. AUTOPSY? | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | COUNTY | STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | John T Bulkeley M.D. Deputy MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED 8-18-79 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | John T Bulkeley ADDRESS Salisbury, Md. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE Burial 8/21/79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park | | | 23d. LOCATION CITY OR TOWN Balto. | | | COUNTY | STATE | Md. | | |
| 24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. | | | ADDRESS 9705 Belair Rd. Balto. Md. 21236 | | | 25a. DATE REC'D. BY REGISTRAR AUG 21 1979 | | | 25b. REGISTRAR'S SIGNATURE John T Bulkeley | | | | | | | |
| BP | | DHMH - 17 (VR A15 ME(5)) 30M 7/73 | | | | | | | | | | | | | | |



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IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | 9 2 1 0 4 0 | |
|--|--|--|---|--|--|--|--|--|---|--|--|--|--|
| | | | | | | | | | | | | REG. NO. | |
| 1 - FOR STATE REGISTRAR | | | I. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | |
| | | | ROSE AUGUSTA Ardis | | | | | | August 10, 1979 | | | 5:40 PM | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| Female | | | White | | | Jan. 18, 1894 | | | 85 YRS. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Maryland | | | USA | | | | | | Wicomico | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Salisbury | | | Peninsula General Hospital | | | | | | Seamstress | | | Shirt Mfg. | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS | |
| Maryland | | | Wicomico | | | Salisbury | | | | | | 314 Charles St. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | 16. SOCIAL SECURITY NO. | | | 17. INFORMANT (son) ADDRESS | | | | |
| John Williams | | | Lillie | | | 214-10-6986 | | | Mr. J. William Phipps, Salisbury, Md. | | | 220 Chestnut Way | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 18b. SOCIAL SECURITY NO. | | | 18c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 18d. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410- | | | 18e. DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | 18f. DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/14/79 to 8/10/79, 19 79, to 8/10/79, 19 79, that (I) (we) lost saw the deceased alive on 8/10/79, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d. DATE SIGNED | | | 8/10/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | | | |
| BENITO S. CHAN | | | 547-3 Riverside Drive Salisbury | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 8/14/79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery | | | 23d. LOCATION CITY OR TOWN Salisbury, Wic., Maryland | | | COUNTY STATE | |
| 24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Md. | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | |

the principal regulars

on board

Notice of latest movements

available

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, or by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | 9 | 2 | 1 | 0 | 4 | |
|---|--|--|---|--|--|---|--|--|---|--|--------|--|---------|---|------|-----------------------------------|--|
| | | | | | | | | | | | | REG. NO. | | | | | |
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH | | | | | | | | | 2b. HOUR | | | | | |
| (TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | MONTH | | DAY | YEAR | 2b HOUR | |
| CHARLES HENRY | | | | | | Baker | | | | | | August | | 18 | 1979 | 5:45 AM | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | # UNDER 24 HRS | | | |
| Male | | | White | | | MONTH 6 DAY 27 YEAR 1887 | | | 92 | | | MONTHS | | DAYS | | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | YRS | | | | | |
| Delaware | | | U.S.A. | | | | | | Wicomico | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HIGH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Salisbury | | | Peninsula General Hsp. | | | | | | | | | Retired | | | | Farming | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS | | | | | |
| Maryland | | | Wicomico | | | Pittsville | | | | | | Box 180 | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | |
| Louder + Baker | | | Hettie Moore | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| NO | | | 222-10-0457A | | | Mrs Oscar White | | | Pittsville, Md | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): | | | | | | | | | | | | | | | | | |
| 4140 Respiratory Arrest | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | | | | | |
| { DUE TO, OR AS A CONSEQUENCE OF (b): Congestive Heart failure, Cardiogenic shock | | | | | | | | | | | | | | | | | |
| { DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerotic coronary artery disease | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): chronic obstructive pulm. disease, Diabetes mellitus, | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | COUNTY | | STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8.15 AM to 8.18 PM, 1979, to 8.18 PM, 1979, that (I) (we) last saw the deceased alive on 8.17 PM, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d. DATE SIGNED | | | | | | | | |
| Slaggar | | | MD | | | | | | | | | | 8/18/79 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | 547 Riverside Drive Suite E Salisbury | | | | | | | | | | | |
| D. SLAGGAR | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION | | | | | | | | |
| Burial | | | 8/21/1979 | | | Pittsville Cem | | | Pittsville, Wic., Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Hill-Baker-Bounds | | | Salisbury, Md. | | | | | | AUG 24 1979 | | | Hill-Baker-Bounds | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please retain by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. | | | | | | | | |
|---|--|--|---|--------|------|--|--|--|--|-------------------------------------|---------------------------------|--|---|-----------------------------------|---|---|--------------------|--|--|--|
| 1. FOR STATE REGISTRAR | | | 2. DATE OF DEATH MONTH DAY YEAR | | | | | | | | | 2b HOUR | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 3. SEX | | | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN. | | | | |
| <i>Hortense Leatherbury Barkley</i> | | | | | | <i>Female</i> | | | <i>Negro</i> | <i>6 11 16</i> | <i>63</i> | | | <i>August 2 1979</i> | | <i>245-250 M</i> | | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 | | | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | 10 CITY OR TOWN OF DEATH | | | | | | | |
| <i>Mt. Vernon, Md.</i> | | | <i>U.S.A.</i> | | | | | | | <i>Wicomico</i> | | | <i>Salisbury</i> | | | | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE) | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| <i>Peninsula General Hospital</i> | | | <i>Housewife</i> | | | | | | | | | <i>Domestic</i> | | | | | | | | |
| 13a. STATE <i>Md.</i> | | | 13b. COUNTY <i>Wicomico</i> | | | 13c. CITY OR TOWN <i>Salisbury</i> | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| | | | | | | | | | | | | | | | <i>Sadie</i> | | <i>Leatherbury</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <i>NO</i> | | | 16b. SOCIAL SECURITY NO. | | | 16c. INFORMANT | | | 17. ADDRESS | | | 18. CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| | | | | | | | | | | | | | | | <i>2500</i> | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | DUE TO, OR AS A CONSEQUENCE OF (b) <i>Other silent heart Disease</i> | | | DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes, Arteria</i> | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | | <i>Pulmonary</i> | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 19c. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21c. LOCATION STREET | | | 21d. CITY OR TOWN | | | 21e. COUNTY | | 21f. STATE | | | | | | |
| 21g. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7/28/79</i> , 19 <i>79</i> , to <i>8/2</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>8/2</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death. | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Constantine J. Tan</i> | | | | | | | | | | | | | 22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | 22f. DATE SIGNED <i>8/2/79</i> | | | | | | | | | | | | | | |
| <i>Constantine J. Tan</i> | | | <i>547-D Riverside Dr. Salisbury, MD</i> | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION CITY OR TOWN | | | 23e. COUNTY | | 23f. STATE | | | | | | |
| <i>Burial</i> | | | <i>8-5-79</i> | | | <i>Green Acres Mem. Pk.</i> | | | <i>Salisbury</i> | | | <i>Wicomico</i> | | <i>Md.</i> | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| <i>Jolley Memorial Chapel</i> | | | <i>Rt. #3 Jersey Shore, Md.</i> | | | | | | | | | <i>AUG 8 1979</i> | | <i>Hortense Leatherbury</i> | | | | | | |

11000100

Engineering Services Department - Grade 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 21043 | | | | | | |
|---|--|--|---|--|--|---|--|--|--|--|------------------|--|---------------|--|-----|----------|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| RAY ALBERT BEERS | | | | | | | | | | | | AUGUST 3 1979 | | | | 10 00 AM | | |
| 3. SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH MONTH DAY YEAR April 27, 1921 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Salisbury, Md. | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | | 10a. USUAL OCCUPATION Main. Sup. | | 12b. KIND OF BUSINESS OR INDUSTRY State Hosp. | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS Parker Road, Rt. 8 | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Wicomico | | | 13c. CITY OR TOWN Salisbury | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS Etta Marie Grubb | | 13f. LAST | | | | |
| 14. FATHER'S NAME FIRST Roy MIDDLE Agustus LAST Beers | | | 15. MOTHER'S MAIDEN NAME Etta Marie Grubb | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. WW II 212-12-3008 | | | 17. INFORMANT (wife) Mrs. Janice H. Beers | | ADDRESS Same as 13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) or (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>410 - Acute Myocardial Infarction</i> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>Diabetes Mellitus</i> | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>8/11/79</i> , 19 <i>79</i> , to <i>8/11/79</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>O. J. Burton, M.D.</i> | | | | | | 22c. DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22d. DATE SIGNED | | <i>8/3/79</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 8/6/79 (01) | | | 23c. NAME OF CEMETERY OR CREMATORIAL Mardela Cemetery | | | 23d. LOCATION CITY OR TOWN Mardela, Wicomico, Md. | | COUNTY | | STATE | | | | | |
| 24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md. | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR AUG 6 1979 | | | 25b. REGISTRAR'S SIGNATURE <i>Holloway</i> | | | | | | | | | |

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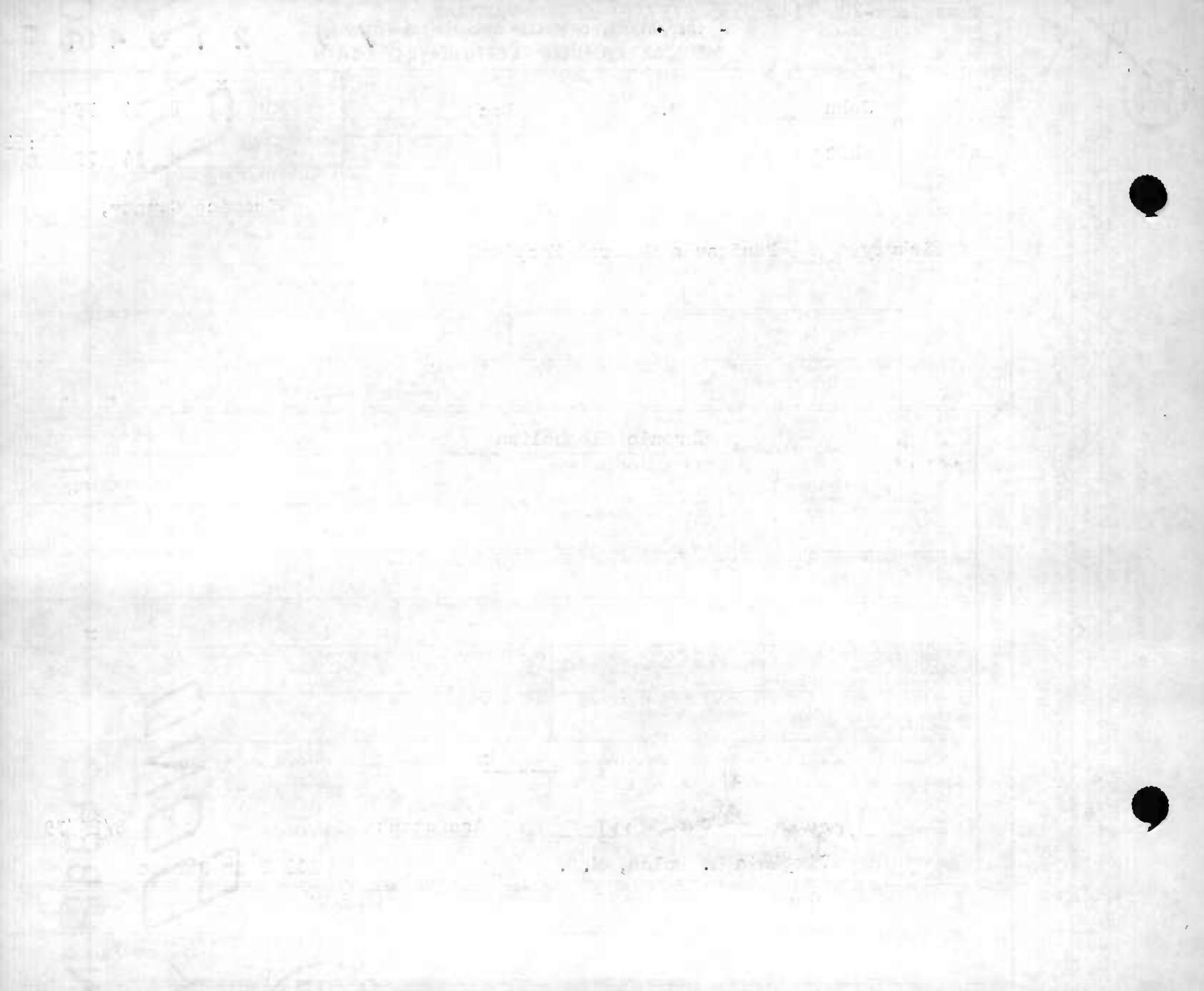
~~XX~~
**Items #18a-22a Film G535 9/19/79 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

21044
REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
IVR A15 ME(5)
15M 7/76

| | | | | | | | | | | |
|---|---------|--|------------------------------------|---|----------------------------------|--|---|---|----------|----------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN <input checked="" type="checkbox"/> ESTI- DEATH MATED <input type="checkbox"/> | MONTH | DAY | YEAR | 2b. HOUR MONTH DAY YEAR |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YR. MONTHS DAYS | 8. IF UNDER 24 HRS. HOURS MIN | 2c. DATE PRONOUNCED DEAD | 8. 14 19 79 | 11:53 | 11:53 AM | |
| Male | White | 7/20/1934 | 45 yrs. | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| New Jersey | | USA | | | | Wicomico County, MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Salisbury | | Peninsula General Hospital | | | | Sales Manager | | Insurance | | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 1326 Middle Neck Drive | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | |
| Cyrill M. Bock | | Angelena Greco | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT (wife) Mrs. Margaret A. Bock, Salisbury, Md. | | ADDRESS P.O. Box 1221 | | | | |
| 303- | | Chronic Alcoholism | | | | | | | | |
| Part 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | |
| Part 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b). | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | STATE | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (TYPE OR PRINT) | | TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER | | | | DATE SIGNED 8/15/79 | | | | |
| Virginia L. Dolan, M.D. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8/20/79 | | 23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park | | 23d. LOCATION CITY OR TOWN Salisbury, Wicomico, Maryland | | 25a. DATE REC'D. BY REGISTRAR AUG 21 1979 | | |
| 24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, | | ADDRESS Salisbury, Maryland | | | | | | 25b. REGISTRAR'S SIGNATURE <i>Holloway</i> | | |



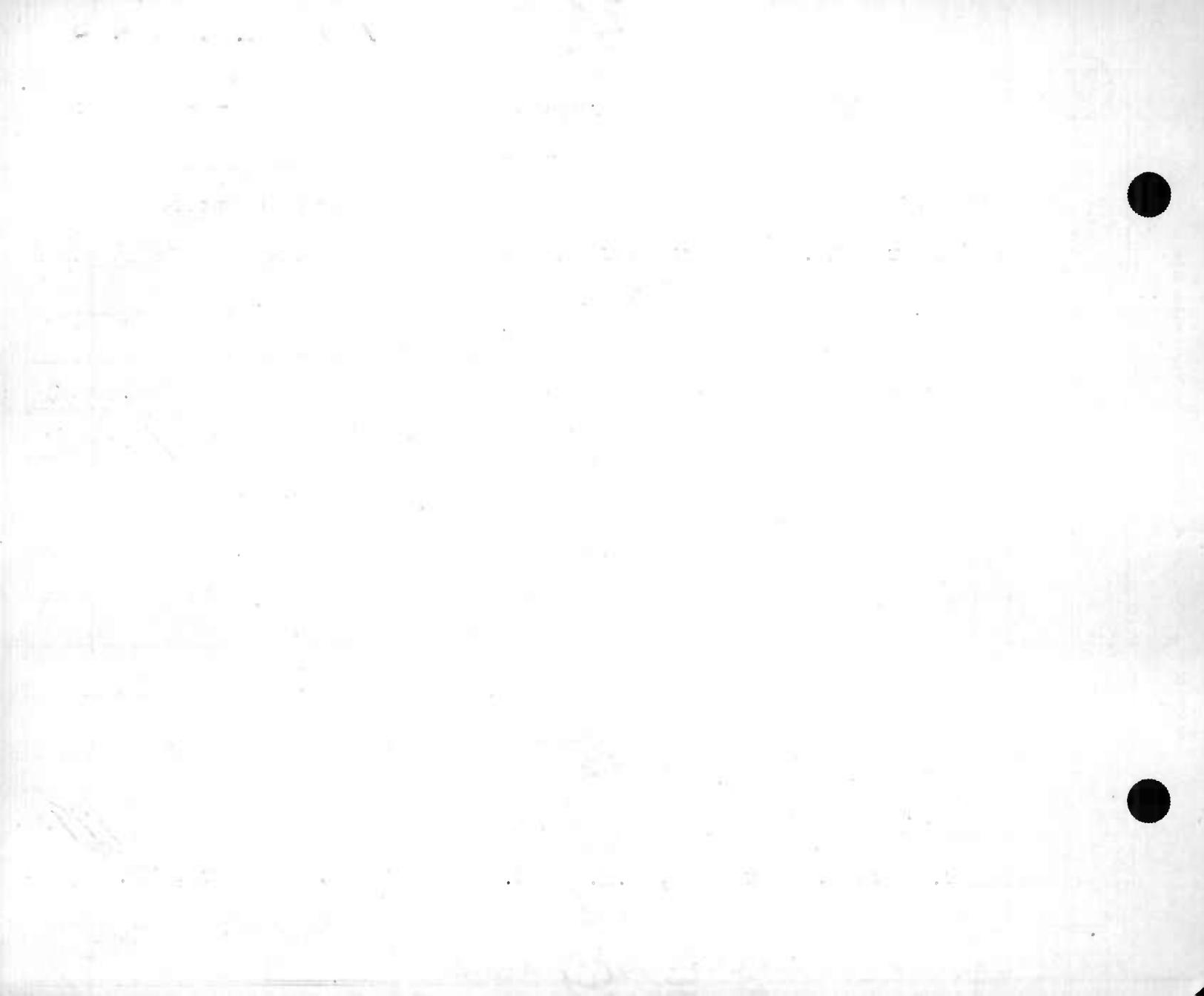
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | REG. NO. 9 2 1 0 4 5 | | |
|--|--|--|--------------------------|--|--|--|---|---|
| 1 - STATE REGISTRAR | | | 2a. DATE OF DEATH 8-6-79 | | | 2b. HOUR A. 8:00 | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Nellie K. | MIDDLE | LAST Bounds | | | | |
| 3. SEX F | | 4 RACE W | | 5. DATE OF BIRTH MONTH 4 DAY 24 YEAR 94 | | 6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico County MD. | | |
| 10 CITY OR TOWN OF DEATH Salisbury, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Salisbury Nursing Home | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OPERATOR | | 12b. KIND OF BUSINESS OR INDUSTRY TELEPHONE | |
| 13a. STATE MD | | 13b. COUNTY WIC | | 13c. CITY OR TOWN SHARPTOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS |
| 14. FATHER'S NAME FIRST J. Wilson Bounds | | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST RACHEL BARKLEY | | | | LAST |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 216-07-39364 | | 17. INFORMANT Vicki Harris | | ADDRESS Sharpstown, Md. | | 18. APPROXIMATE INTERVAL BETWEEN DEATH AND DEPL. |
| 18. CAUSE OF DEATH (Enter only one cause of death for 18, 18a and 18b) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4340 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO OR AS A CONSEQUENCE OF (b) General Pneumonia DUE TO OR AS A CONSEQUENCE OF (c) | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | COUNTY | STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/5/79 to 8/6/79, that (I) (we) last saw the deceased alive on 8/5/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death. | | | | | | | | |
| 22b. SIGNATURE Dr. Earl M. Beardsley | | 22c. DEGREE MD | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22e. DATE SIGNED 8/6/79 | | |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Earl M. Beardsley, M.D. | | 22g. ADDRESS Rt. 50 & Civic Ave, Salisbury, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 8-8-79 | | 23c. NAME OF CEMETERY OR CREMATORIAL FIREWORKS CEM | | 23d. LOCATION CITY OR TOWN SHARPTOWN | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR AUG 13 1979 | | 25b. REGISTRAR'S SIGNATURE Harry McBrady | | |
| IRVING FEDERICK HORN | | SHARPTOWN, MD. | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trouant permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to Burial, Cremation, or Removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other presumptive event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

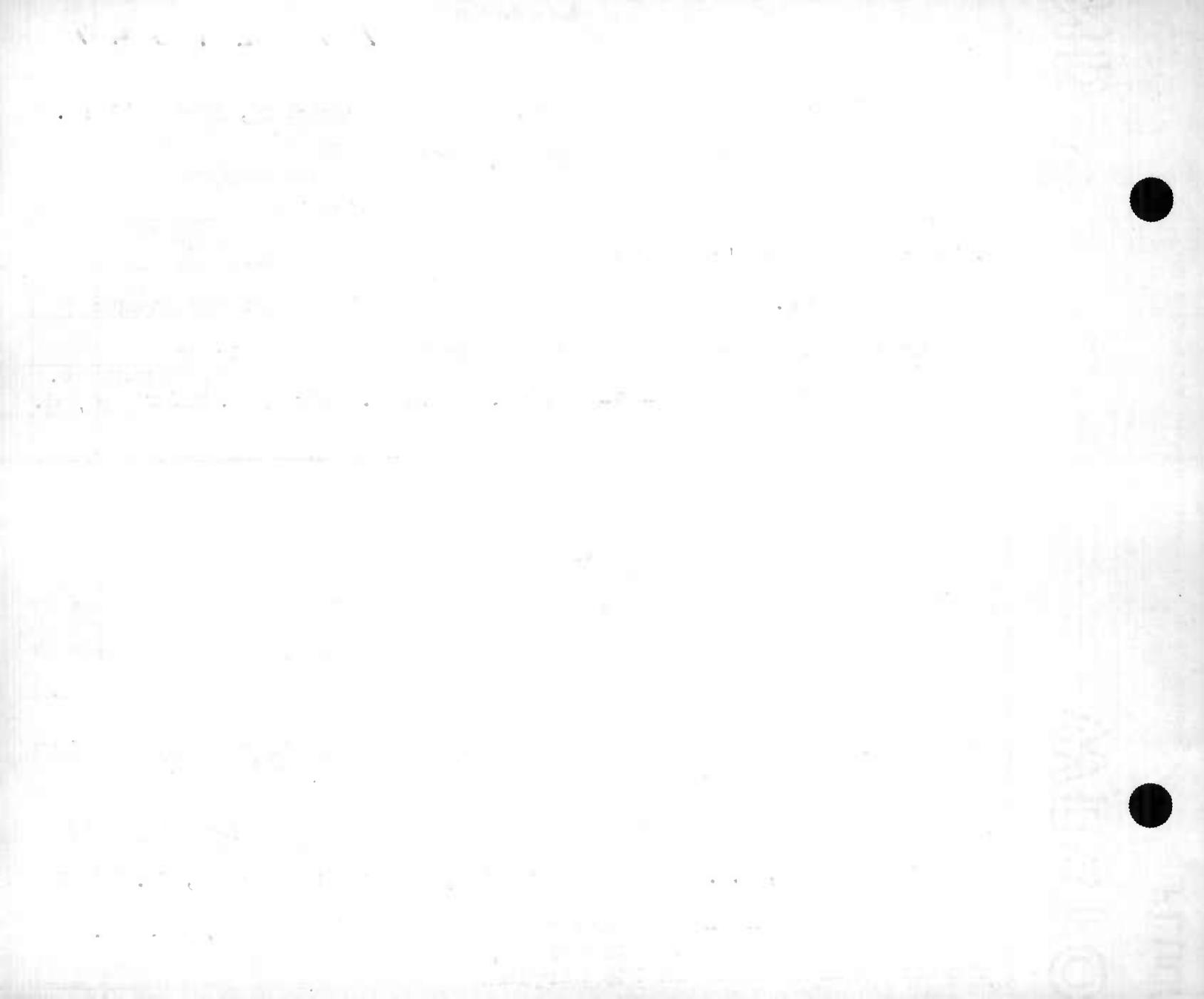
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 9 21046 | | |
|---|--|--|---|--|--|--|--|--|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR August 29 1979 | | | | | | | | | 2b. HOUR 1P M | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE | | | LAST | | | | | | | | |
| Thomas Gilbert | | | | | | Bradley | | | | | | | | |
| 3. SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH MONTH DAY YEAR May 23, 1912 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | | 7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | | 10. CITY OR TOWN OF DEATH Salisbury | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson | | | 12b. KIND OF BUSINESS OR INDUSTRY Twilley | | | 10. CITY OR TOWN OF DEATH Salisbury | | | | | |
| 13a. STATE Md. | | | 13b. COUNTY Dor. | | | 13c. CITY OR TOWN Cambridge | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 7 Hatsawap Road | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas Wesley Bradley | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Twilley | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 218-03-7545 | | | 17. INFORMANT Mrs. Lenna Belle Bradley, Cambridge, Md. | | | ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18, if one) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-24 1979 to 8-2 1979, and that (I) (we) last saw the deceased alive on 8-24 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | | | | | | | | 22c. DATE SIGNED 8-29-79 | | |
| 22b. SIGNATURE <i>A. Barnes</i> | | | 22d. DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> | | | MEDICAL DIRECTOR <input type="checkbox"/> | | | STAFF PHYSICIAN <input type="checkbox"/> | | |
| 22e. ADDRESS | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Aug. 31, 1979 | | | 23c. NAME OF CEMETERY OR CREMATORIAL East New Market | | | 23d. LOCATION CITY OR TOWN Cem. East New Mkt., Dor. Md. | | | COUNTY STATE | | |
| 24. FUNERAL DIRECTOR NAME Thomas Funeral Home, Cambridge, Md. | | | 25a. DATE REC'D. BY REGISTRAR SEP 5 1979 | | | 25b. REGISTRAR'S SIGNATURE <i>Robert J. Crowley</i> | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 9 2 1 0 4 7 | | | | |
|--|--|------------------------------|---|---|--|--|--------------------------------------|---|--|---|--------------------------------|--|-----------------------------------|--|
| 1 - FOR STATE REGISTRAR | | | 2a DATE OF DEATH MONTH DAY YEAR | | | | | | | 2b HOUR | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | August 25, 1979 | | | | | | | 10:40 PM | |
| Winthrop Lee Bradshaw | | | | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | IF UNDER 1 YEAR # UNDER 24 HRS | | | |
| Male | | White | | July 15, 19081 | | | 78 | | | | MONTHS DAYS HOURS MIN | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | YRS. | | | |
| Maryland | | US | | | | | Wicomico | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Salisbury | | | Deer's Head Center | | | | | | | Salesman | | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Dor. | | 13c. CITY OR TOWN Cambridge | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 208 West End Avenue | | | | |
| 14. FATHER'S NAME FIRST George | | | MIDDLE Winthrop | LAST Bradshaw | 15. MOTHER'S MAIDEN NAME FIRST Ethel | | | MIDDLE | | LAST Cooke | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. WWII | | | 17. INFORMANT 218-03-3401 Mrs. James P. Swing, Jr. Cambridge, Md. | | | ADDRESS 807 Locust St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>chronic myocardial Disease</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u> | | | | |
| 429 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) } DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/25/79</u> to <u>8/25/79</u> , that (I) (we) lost saw the deceased alive on <u>8/25/79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED <u>8/25/79</u> | | | | |
| 22b. SIGNATURE <u>Inja Joe Hwang</u> | | | DEGREE <u>M.D.</u> | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS Deer's Head Center; Salisbury, Md. 21801 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE Burial 8-28-79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Cambridge Cemetery Cambridge, Dor. Md. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR NAME Thomas Funeral Home Box 348 Maryland | | | 25a. ADDRESS Cambridge, | | | 25b. DATE REC'D. BY REGISTRAR AUG 31 1979 | | | 25b. REGISTRAR'S SIGNATURE <u>Hilary McCreedy</u> | | | | | |
| BP _____ | | | | | | | | | | | | | | |
| DHMH-16 20M (VRA 15, 4) 7/78 | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death.

retd by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

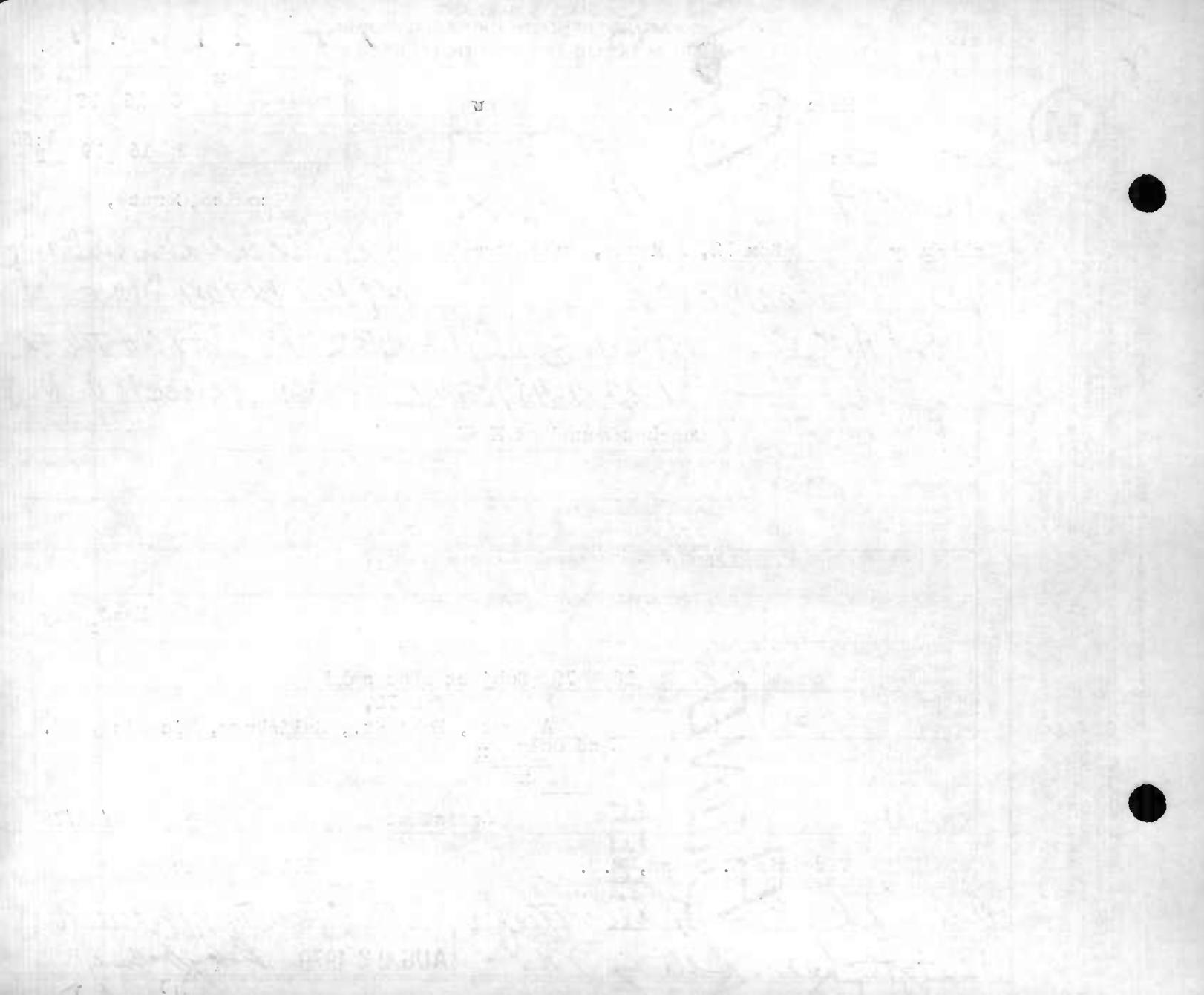
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | 9 | 2 | 1 | 0 | 4 | 8 |
|--|--|--|---|--|--|---|--|--|--|--|--|---|---|---|---|---|---|
| | | | | | | | | | | | | REG. NO. | | | | | |
| 1. FOR STATE REGISTRAR | | | I. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR 3 ¹⁵ 3 P.M. | | | | | |
| LOUIS H BRITTINGHAM | | | | | | | | | AUGUST 22, 1979 | | | | | | | | |
| 3. SEX MALE | | | 4. RACE CAUC. | | | 5. DATE OF BIRTH MONTH DAY YEAR AUGUST 12 1899 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO | | | MD. | | | | | |
| 10. CITY OR TOWN OF DEATH SALISBURY | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PENINSULA GENERAL HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. LUMBERMAN | | | 12b. KIND OF BUSINESS OR INDUSTRY LUMBER | | | | | | | | |
| 13a. STATE Md. | | | 13b. COUNTY WOR. | | | 13c. CITY OR TOWN BERLIN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 109 CEDAR AVE. | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SEWELL BRITTINGHAM | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Rayne | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 217-03-5926 | | | 17. INFORMANT FRANK L. BRITTINGHAM | | | ADDRESS 319 N.Y. AVE SALISBURY, MD. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for part 1b, and its PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiogener Rock</i> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hour | | | | | |
| 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Acute myocardial infarct</i> | | | | | | | | | | | | hour | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Alto Selen</i> | | | | | | | | | | | | ge | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Congestive Heart Failure</i> | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/27/79</u> to <u>8/27/79</u> , that (I) (we) last saw the deceased alive on <u>8/27/79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | 22b. SIGNATURE <i>John G. Green</i> DEGREE | | | | | |
| 22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | | | 22d. DATE SIGNED 8/22/79 | | | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN G. GREEN | | | 22f. ADDRESS 215 OHIO AVE SALISBURY MD 21801 | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 8/25/79 | | | 23c. NAME OF CEMETERY OR CREMATORIUM MT. PLEASANT CEM. | | | 23d. LOCATION CITY OR TOWN RURAL | | | 23e. COUNTY WICOMICO | | | | | |
| 24. FUNERAL DIRECTOR NAME Jean B. Prettyman | | | ADDRESS 108 Wm. St Berlin, Md. | | | 25a. DATE REC'D. BY REGISTRAR AUG 29 1979 | | | 25b. REGISTRAR'S SIGNATURE Mary McReady | | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 21049 | | | | | | |
|--|--|--|--|---|-------|--|--|--|--|--|-------|---|--|--|--|--------------------------------------|---------------------------|--|
| 1- FOR STATES REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | 2a. DATE KNOWN OF ESTI. DEATH MATED | | MONTH DAY YEAR | 2b. HOUR 2d. HOUR M | |
| | | Mercedes | | | O. | | | | | | Brown | | | <input checked="" type="checkbox"/> | | 8 16 19 79 | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH | | 6. AGE (IN YEARS) LAST BIRTHDAY | | 7. IF UNDER 1 YR. | | 8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN | | 9. DATE PRONOUNCED DEAD | | MONTH DAY YEAR | | 2d. HOUR 4:50 P M | | |
| Female | | Black | | 8-18 1959 | | 71 yrs | | | | | | X | | 8 16 19 79 | | | | |
| 10. BIRTHPLACE, STATE OR NATIONAL COUNTRY | | 11. ADDRESS OF WHERE COUNTED | | 12. OCCUPATION (TYPE OF WORK) EMPLOYER'S WORKING LINE | | | | | | | | | | | | 13b. KIND OF BUSINESS OR INDUSTRY | | |
| Penns | | SA | | John Dolan | | | | | | | | | | | | Wicomico County, MD. | | |
| 14. CITY OF DEATH | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | 16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | |
| Salisbury | | RYLANDER F | | | | | | | | | | | | Wicomico, Salisbury | | | | |
| 17. STATE | | 18. COUNTY | | 19. CITY OR TOWN | | 20. STREET ADDRESS | | | | | | | | | | | | |
| MD | | WICOMICO | | SALISBURY | | 410 BX 7217 DUKE ST | | | | | | | | | | | | |
| 18a. FATHER'S NAME | | MIDDLE | | LAST | | 21. ADDRESS | | | | | | | | | | | | |
| ADOLPHUS C | | | | BULGES | | High Tower | | | | | | | | | | | | |
| 18b. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 18c. SOCIAL SECURITY NO. | | 18d. INFORMANT | | 18e. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | |
| NO | | 14212-1189 | | EARL BULGES | | Princeton N.J. | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Head | | | | | | | | | | | | | | | | | | |
| 9554 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. | | | | | | | | | | | | | | | | | | |
| { DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY? Head Only YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 8 16 19 79 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21d. LOCATION | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | 21g. TITLE (SPECIFY) Assistant, MEDICAL EXAMINER | | 21h. DATE SIGNED 8/18/79 | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | home | | Box 72, | | CITY OR TOWN | | A Route, Duke St., Salisbury, Wicomico, Md. | | COUNTY | | STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Virginia L. Dolan, M.D. | | EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. | | | | | | | | | | | | ADDRESS 111 Penn Street | | | | |
| 23a. BURIAL, CREMATION, REMOVAL CITY | | 23b. DATE 8-21-79 | | 23c. NAME OF CEMETERY OR CREMATORIAL Facility | | 23d. LOCATION CITY, TOWNSHIP, COUNTY | | 23e. DATE RECD. BY REGISTRAR AUG 22 1979 | | 23f. REGISTRAR'S SIGNATURE Larry McCrady | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | | | | | | | | | | | | | | | |
| Next-Door Salis. Md. | | | | | | | | | | | | | | | | | | |
| DHMH - 17 IVR A15 ME(5) 15M 7/76 | | | | | | | | | | | | | | | | | | |



2
1

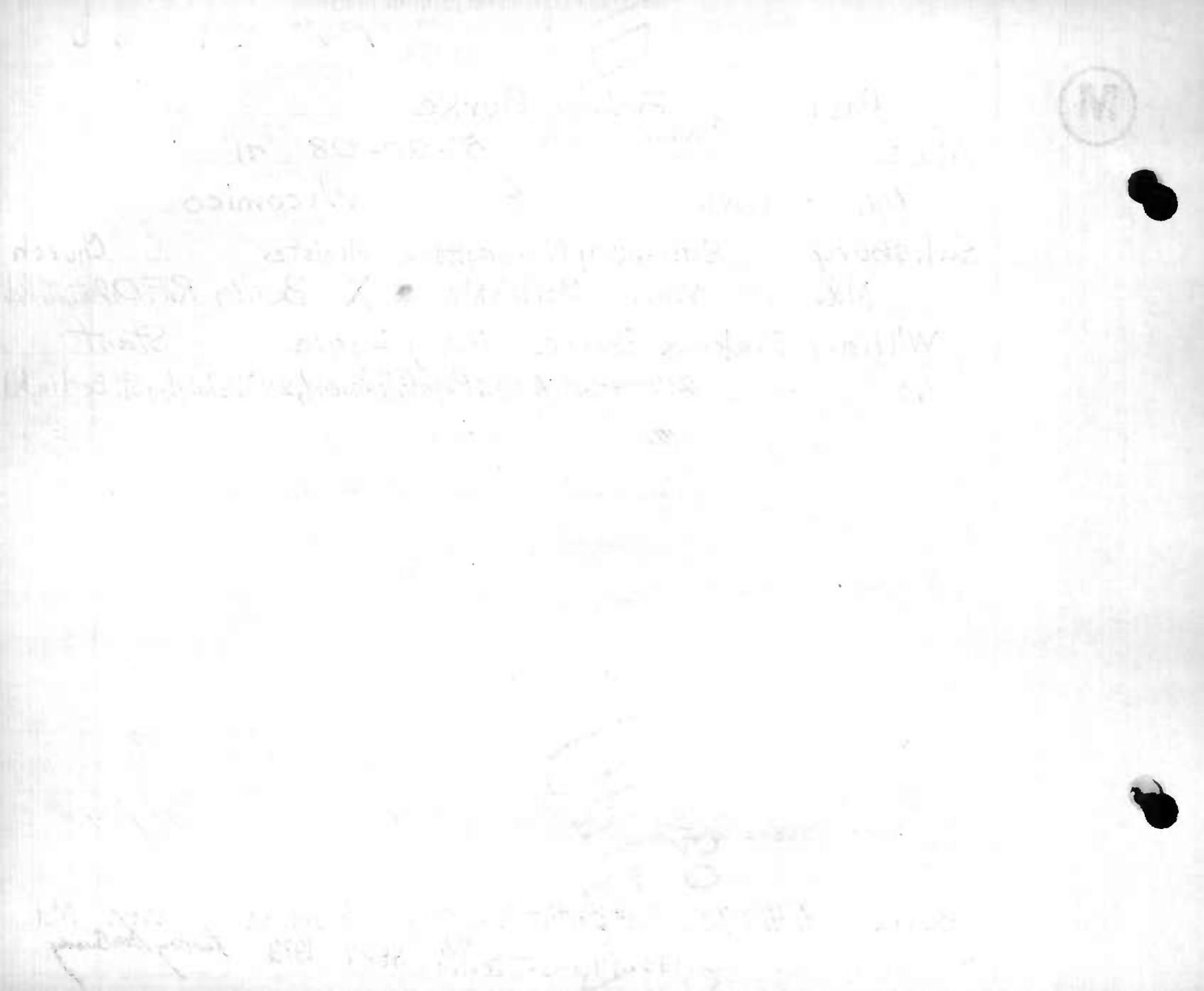
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

21050

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours. Page 4 may be retained by the hospital or attending physician.

To Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, 3, 4, and 5 should be filed with the State Dept. of Health prior to burial, cremation, at removal, and in any event, within 72 hours after death.

| | | | | | | | | |
|--|---|--|--|--|---|-------------------|------------------------|--|
| 1. DECEASED-NAME (Type or print) | First Paul | Middle Frederick Burke | Lost | 20. DATE OF DEATH Month 8 | Doy 31 | Year 79 | 2b. HOUR 11 30 P.M. | |
| 3. SEX Male | 4. RACE Cauc. White | S. DATE OF BIRTH 5-20-08 | 6. AGE (In years lost birthday) 71 YRS. | IF UNDER 1 YEAR MONTHS 0 | IF UNDER 24 HRS. DAYS 0 | HOURS 0 | MIN 0 | |
| 7a. BIRTHPLACE (State or foreign country) Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Wicomico | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Salisbury Nursing Home | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Minister | 12b. KIND OF BUSINESS OR INDUSTRY Church | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | 13c. CITY OR TOWN Berlin R.F.P. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER Berlin R.F.D. Pathell Rd. | | | | | |
| 14. FATHER'S NAME First William | Middle Frederick Burke | 15. MOTHER'S MAIDEN NAME First Mary Lydia | Stant | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | 16b. SOCIAL SECURITY NO. 213-14-6039A | 17. INFORMANT Rev. Hugh G. Townsend, 211 Washington St., Berlin, Md. | Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral hemorrhage 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days | | | | |
| (b) generalized arterio sclerosis | | | | yes | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Diabetic Melitus | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| MEDICAL CERTIFICATION | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1b.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/31 , 19 79 , to 8/31 , 19 79 , that (I) (we) last saw the deceased alive on 8/31 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE Gill Stanley | | 40 DEGREE | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED 9/1/79. | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 9/4/79 | 23c. NAME OF CEMETERY OR CREMATORIAL First Baptist Cemetery | 23d. LOCATION (City or Town) Pocomoke | (County) Wor. Md. (State) | | | | |
| 24. FUNERAL DIRECTOR Anna A. Burdage | ADDRESS 108 Williams St. Berlin | 25a. REC'D BY REGISTRAR Mdy | 25b. REGISTRAR'S SIGNATURE Hillary McCreedy | DATE SEP 7 1979 | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS EXECUTED THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 2 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 21051 | | | | | | | | | |
|--|--|--|--|---|--|--|---|---|--|--------------------------|---|---|-------|---|--|--------------------------------|--|------------------------|--|----------|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | 2a. DATE KNOWN OF DEATH ESTI- MATED | | MONTH DAY YEAR | | 2b. HOUR | | | |
| | | ROBERT | | | F. | | | BURTON | | | | | | <input checked="" type="checkbox"/> 8-26-79 | | 4:07A | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH 7 DAY 8 YEAR 20 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. | | | IF UNDER 1 YR. MONTHS | | IF UNDER 24 HRS. HOURS | | MIN | | 2c. DATE PRONOUNCED DEAD | | MONTH DAY YEAR | | 2d. HOUR | |
| Male | | White | | | | | | | | | | | | | | 8-26-79 | | 19 | | " | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | Peninsula General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | crane operator | | | 12b. KIND OF BUSINESS MANUFACTORY | | | | | | | |
| Salisbury | | | | | | | | | | | | | | steel co. | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Dundalk 21222 | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 811 Murray Pt. Road | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST | | MIDDLE | | | LAST | | | 15. MOTHER'S MAIDEN NAME FIRST | | MIDDLE | | | LAST | | | | | | | | |
| Henry | | | | | Burton | | | Dolores Mills | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | (IF YES, GIVE WAR OR DATES) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT (wife) | | ADDRESS | | | | | | | | | | | |
| Yes | | W.W. II | | | 401-12-8386 | | | Virginia A. Burton, same as #13 | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes | | | | | | | | | |
| Myocardial Infarction 410- Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. | | | | | | | | | | | | | | | | | | | | | |
| } DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b). | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | | | | | | | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY P.M. | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | | | TITLE (SPECIFY) M.D. Deputy | | MEDICAL EXAMINER | | | | DATE SIGNED 8-26-79 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS 409 Camden Ave., Salisbury, Md. | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL burial | | 23b. DATE 8-29-79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Holly Hill Mem. Garden | | | 23d. LOCATION CITY OR TOWN | | | COUNTY | | STATE | | | | | | | | |
| 24. FUNERAL DIRECTOR Bruzdzinski Funeral Home, Essex, Md. | | ADDRESS | | | | | | | | | Baltimore, Md. | | | | | | | | | | |
| DHMH - 17 (VR A15 ME (5)) 30M 7/73 | | | | | | | | 25a. DATE REC'D. BY REGISTRAR AUG 9 1979 | | | 25b. REGISTRAR'S SIGNATURE Loyalty McBrady | | | | | | | | | | |

solid

so last night came. I think he's still there.

but all went well & we're now on our way.

all day,

so I guess we'll get there by nightfall.

science lab

X Y Z

water

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page _____
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director it should be detached for use as the Burial-Transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 9 2 1 0 5 2 | | | | | |
|--|--|---|-------|--|-----------|-----------------------|--|----------------|---|--|------------------|--|---|--|----------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a DATE OF DEATH | | | MONTH | DAY | YEAR | 2b HOUR | | | | | |
| <i>HARRY FRANKLIN CAMPBELL</i> | | | | | | <i>AUGUST 14 1979</i> | | | 7 | 00 | PM | 7 00 PM | | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YR. MONTHS | | | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN | | | | |
| <i>m</i> | | <i>W</i> | | <i>MONTH 4 DAY 27 YEAR 92</i> | | | <i>87</i> | | | | | | | | | | |
| 7a BIRTHPLACE STATE OR FOREIGN COUNTRY | | 7b CITIZEN OF WHAT COUNTRY? | | 8 | | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| <i>Penna</i> | | <i>USA</i> | | | | | | | | <i>Wicomico</i> | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| <i>Salisbury</i> | | <i>Peninsula General Hospital</i> | | | | | | | | | | <i>Truck Co. Owner</i> | | | <i>Trucking</i> | | |
| 13a STATE | | 13b COUNTY | | 13c CITY OR TOWN | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e STREET ADDRESS | | | | | | | |
| <i>Penna</i> | | <i>Perry</i> | | <i>MILLERSBORO</i> | | | | | | <i>RFD #1</i> | | | | | | | |
| 14. FATHER'S NAME FIRST | | MIDDLE | | LAST | | | 15. MOTHER'S MAIDEN NAME FIRST | | | MIDDLE | | | LAST | | | | |
| <i>B. F. Campbell</i> | | | | | | | <i>IDA SARVER</i> | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 16c INFORMANT | | | 17. ADDRESS | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| <i>No</i> | | <i>180-26-6576</i> | | <i>H-Baw. CAMPBELL, Millersboro, R. Pa</i> | | | | | | <i>1 week</i> | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for 1a, b, and c PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE 1a) <i>Cerebrovascular Accident</i> | | | | | | | | | | | | | | | | | |
| 436- Conditions, if any, which gave rise to immediate cause 1a), stating the underlying cause last | | | | | | | | | | | | | | | | | |
| b) <i>Hypertension</i> | | | | | | | | | | | | | | | | | |
| c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a) | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | | CITY OR TOWN | | COUNTY | STATE | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from | | <i>8.14 79</i> | | <i>7-25 1979</i> | | | <i>to 8.14 79</i> | | | | | | | | | | |
| now deceased alive on | | <i>8.14 79</i> | | <i>and that in my (our) opinion death occurred on the date and hour and from the causes stated</i> | | | | | | | | | | | | | |
| 22b. SIGNATURE | | <i>Roger C. Merrill</i> | | DEGREE | | | ATTENDING PHYSICIAN | | MEDICAL DIRECTOR <input checked="" type="checkbox"/> | STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | | | <i>MD</i> | | | <i>KAY AVE</i> | | <i>8.14.79</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIUM | | | 23d. LOCATION CITY OR TOWN | | COUNTY | STATE | | | | | | | |
| <i>Burial</i> | | <i>8/18/79</i> | | <i>NEWPORT Oliver Twp., Perry Co., Pa</i> | | | <i>SALISBURY MD 21801</i> | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25. DATE REC'D. BY REGISTRAR | | | 26. DECEASED'S SIGNATURE | | | | | | | | | | |
| <i>Holloway's Fun' Home PA</i> | | <i>SALISBURY MD</i> | | <i>AUG 21 1979</i> | | | <i>John C. Campbell</i> | | | | | | | | | | |

190036

Japan - recently created colony

Japan - recently created colony

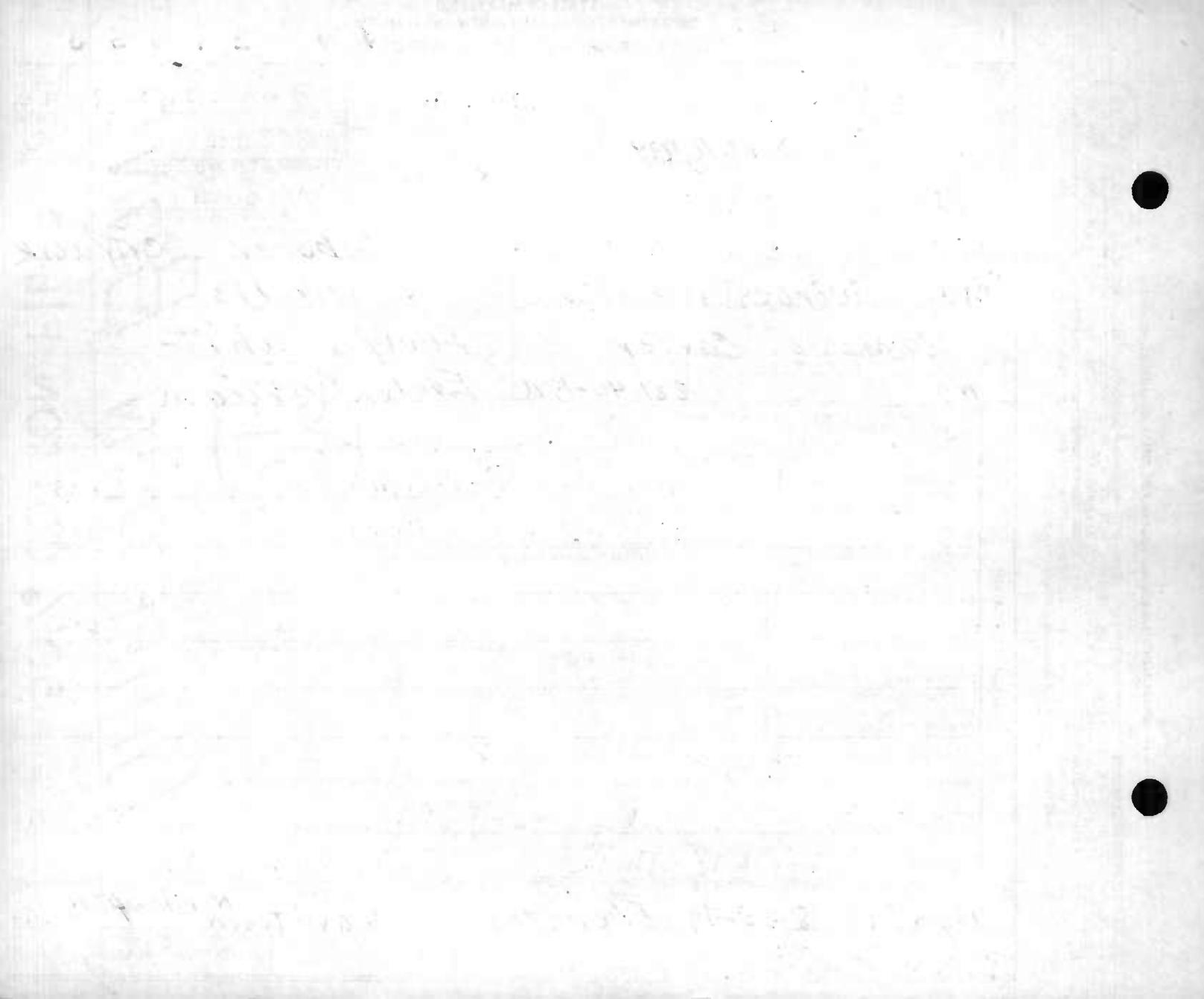
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 21053

| | | | | | | | | | | | | | | | | |
|--|--|---|--|---|---------------------------------|---|---|--|---|--|--|---|------------------|--|------------------|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR OF ESTI- MATED <input type="checkbox"/> Aug 16 1979 9 AM | | | | | | | | | | 2b. HOUR 9 AM | | | |
| 1. DECEASED NAME (TYPE OR PRINT) William Carter | | | MIDDLE | | | LAST | | | | | | | | | | |
| 3. SEX Male | | 4. RACE B | | 5. DATE OF BIRTH MONTH Sept. DAY 10 YEAR 1934 | | 6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS. | | 7. IF UNDER 1 YR. MONTHS 0 DAYS 0 | | 8. IF UNDER 24 HRS. HOURS 0 MIN 0 | | 2c. DATE PRONOUNCED DEAD Aug 16 1979 | | | 2d. HOUR 9 AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | | 12b. KIND OF BUSINESS OR INDUSTRY CITY work | | | | | | | |
| 13a. STATE Md. | | | 13b. COUNTY Worcester | | 13c. CITY OR TOWN Berlin | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Box 193 | | | | | | | |
| 14. FATHER'S NAME FIRST Samuel MIDDLE Carter LAST | | | 15. MOTHER'S MAIDEN NAME Evelyn White | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 227-40-7926 | | | 17. INFORMANT Evelyn Kellam | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: metabolic acidosis IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF hepatitis failure DUE TO, OR AS A CONSEQUENCE OF alcoholic cirrhosis | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion | | | | | | | | | | | | | |
| ACTUAL SIGNATURE John G Bulkeley | | | TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER | | | DATE SIGNED 8-17-79 | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) John T Bulkeley | | | ADDRESS Salisbury, Md. | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIES) Burial | | | 23b. DATE 8-20-79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Epenerzer | | | 23d. LOCATION CITY OR TOWN Northampton | | | | | | | |
| 24. FUNERAL DIRECTOR Reverend John T Bulkeley | | | ADDRESS Acme, Va. 23301 | | | 25a. DATE REC'D. BY REGISTRAR AUG 24 1979 | | | 25b. REGISTRAR'S SIGNATURE John T Bulkeley | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR USE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME (5))
30M 7/73



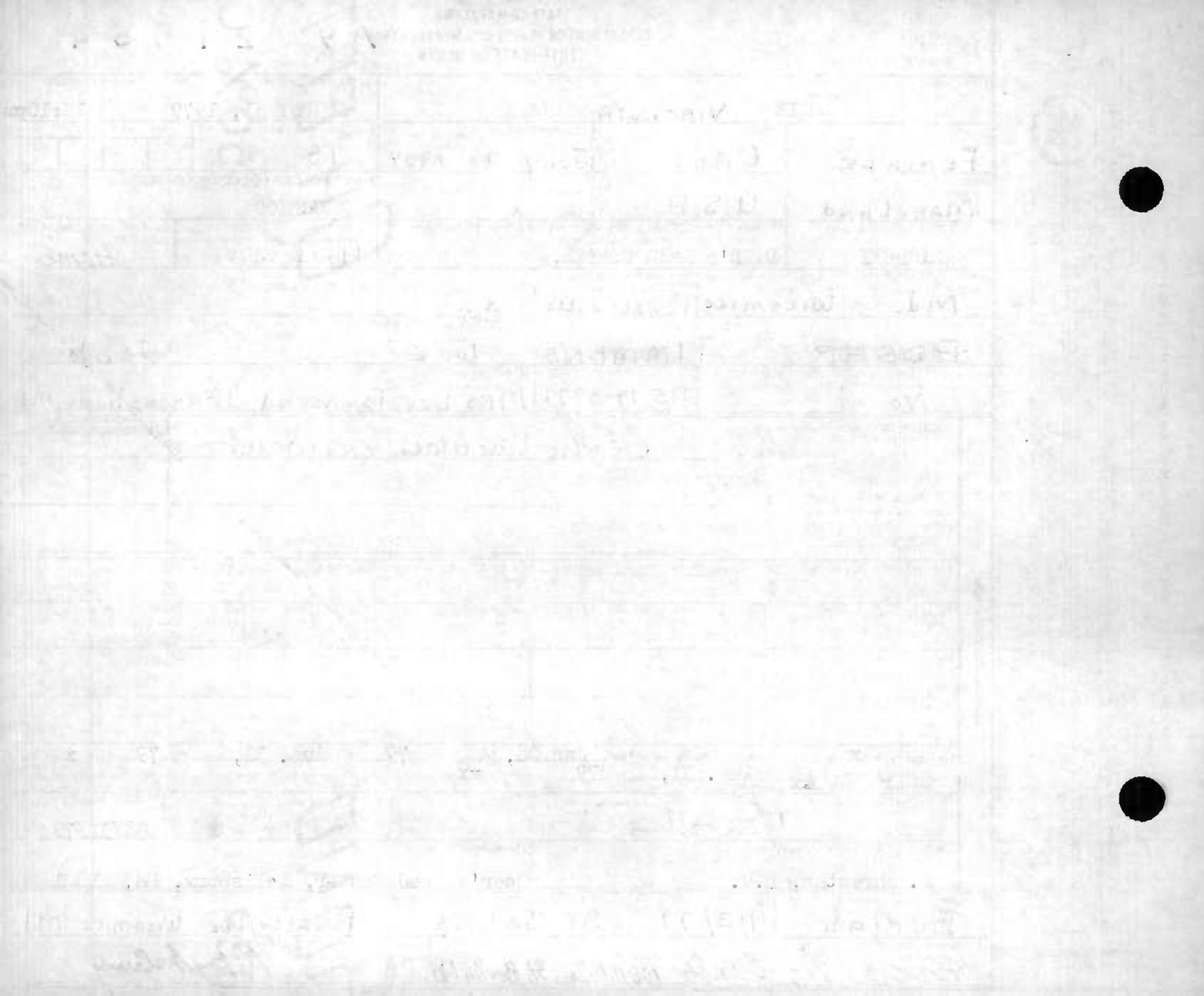
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | 9 | 2 | 1 | 0 | 5 | 4 | | | | | |
|--|--|---|------------------------|---|-------------------|---|-----|---|---------------------|-------------------------------------|--|--|--|--|--|
| | | | | | REG. NO. | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | | | | | | |
| MARGIE | | VIRGINIA | CLARK | | AUGUST 31, 1979 | | | | 12:10pm | | | | | | |
| 3. SEX FEMALE | | 4. RACE CAUC. | | 5. DATE OF BIRTH JULY 20 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 | | IF UNDER 1 YEAR MONTHS | | IF UNDER 24 HRS HOURS | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO | | YRS. | | MD. | | | | | |
| 10. CITY OR TOWN OF DEATH SALISBURY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DEER'S HEAD CENTER, | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY WICOMICO | | 13c. CITY OR TOWN POWELLVILLE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | | | | |
| 14. FATHER'S NAME FIRST SETH | | MIDDLE GIER | LAST TIMMONS | 15. MOTHER'S MAIDEN NAME FIRST LEE | | MIDDLE | | | LAST Webb | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 215-14-3977 | | 17. INFORMANT | | ADDRESS | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jun 08, 1979 , to Aug. 31, 1979 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on Aug. 31, 1979 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> not view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>M. Shrestha</i> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> | | MEDICAL DIRECTOR <input type="checkbox"/> | | STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 08/31/79 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Shrestha M.D. | | 22e. ADDRESS | | Deer's Head Center, Salisbury, Md. 21801 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/3/79 | | 23c. NAME OF CEMETERY OR CREMATORIAL ST. JOHNS | | 23d. LOCATION CITY OR TOWN POWELLVILLE | | COUNTY WICOMICO | | STATE Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>Anna A. Bentley</i> | | ADDRESS <i>108 Williams St, Berlin, MD</i> | | 25a. DATE REC'D. BY REGISTRAR REG. TRAP'S SIGNATURE SEP 6 1979 | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 7921055 | | | | | | |
|--|--|------------------------------------|--|--|--------|--|---|---|--|--|----------------------------------|---|--|--------|--|--|---------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | FIRST | MIDDLE | LAST | 2a DATE OF DEATH | MONTH | DAY | YEAR | 2b HOUR | | | | | | | |
| Robert | | | | H. | | Cooper | AUGUST | 26 | 1979 | 7 30 PM | | | | | | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | | | | | | | |
| Male | | Negro | | 1 - 7 - 1912 | | | 67 yrs | | | | | | | | | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | | MD. | | | | | | | | |
| 10 CITY OR TOWN OF DEATH Salisbury | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tailer | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a STATE Md. | | 13b COUNTY Dor. | | 13c CITY OR TOWN Cambridge | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS 809 Truman Ave. | | | | | | | | | | |
| 14 FATHER'S NAME William B. C. | | | | 15 MOTHER'S MAIDEN NAME Mable | | | | 16 ADDRESS - Brittingham | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b SOCIAL SECURITY NO. 220-30-2489 | | | | 17 INFORMANT (Sister) ADDRESS Mildred Anderson 514 Pine St. Camb., Md. | | | 16 | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| 5860 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first { b). DUE TO, OR AS A CONSEQUENCE OF Ruptured Viscera | | | | | | | | | | | | | | | | | | |
| c). DUE TO, OR AS A CONSEQUENCE OF Nephritis | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Chronic Renal Failure Secondary to Nephrosclerosis | | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 26, 1979, to Aug 26, 1979, that (I) (we) last saw the deceased alive on Aug 26, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | 22b. SIGNATURE Benedict S. Chan MD | | DEGREE | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | IN DATE SKINED 8/26/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BENITO S. CHAN | | | 22e. ADDRESS 547-0 Riverside Dr. Salisbu | | | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 8/30/79 | | | 23c NAME OF CEMETERY OR CREMATORIAL Bethel AME Cem. | | | 23d. LOCATION CITY OR TOWN Cambridge, Dor. | | | COUNTY STATE Md. | | | | | | |
| 24 FUNERAL DIRECTOR L.H. Boardley | | | ADDRESS 603 Washington St. Camb. Md. | | | 25a. DATE REC'D. BY REGISTRAR AUG 31 1979 | | | 25b. REGISTRAR'S SIGNATURE Loyalty McElroy | | | | | | | | | |

McCormick

Lake Erie Inland Navigation

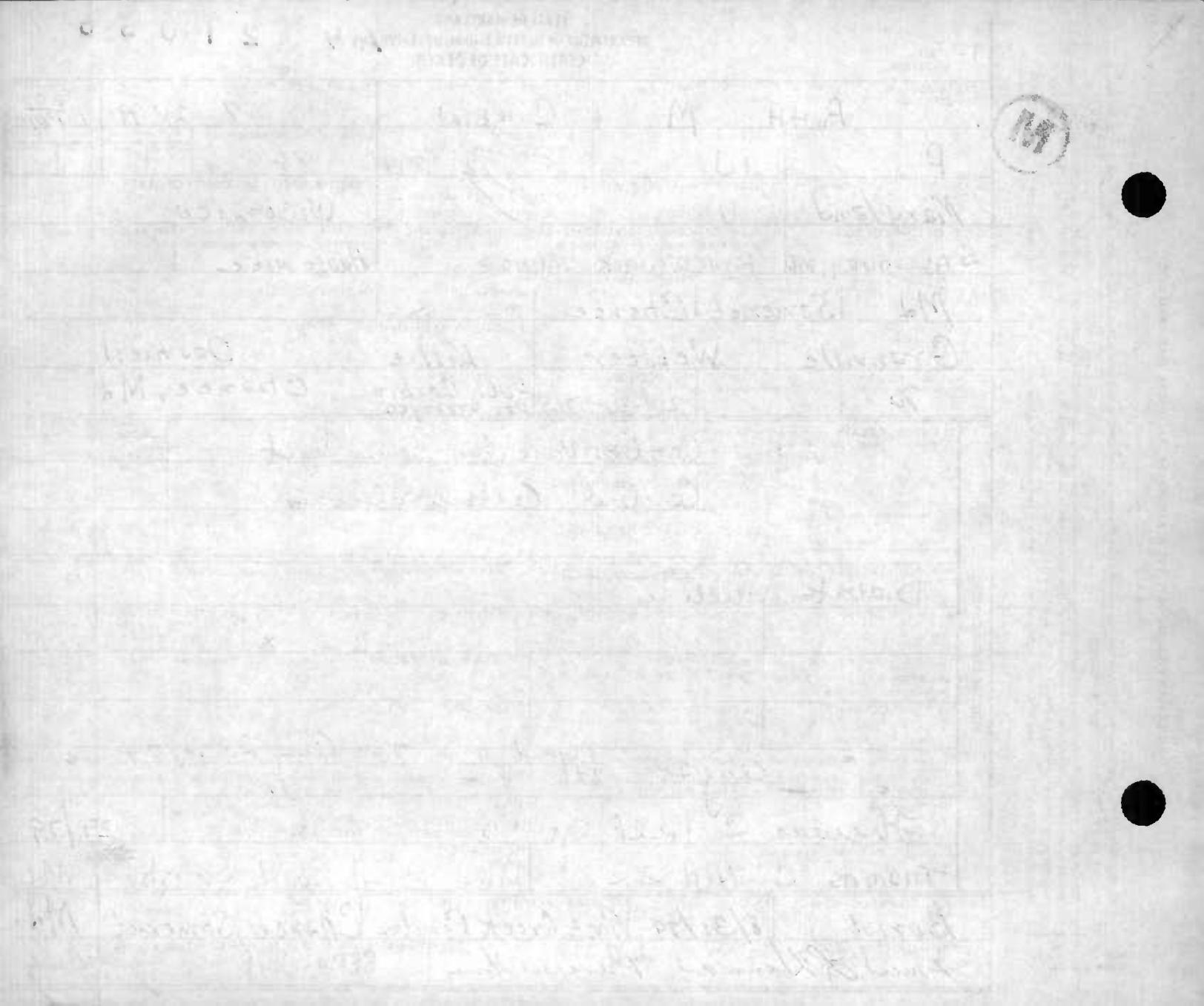
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Form 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 21056 | | |
|---|---|---|--|---|---|--|--|---|-------------------------------------|------------------------------|--------|--|
| 1 - FOR STATE REGISTRAR | 1 DECEASED NAME (TYPE OR PRINT) | FIRST | MIDDLE | LAST | 2a DATE OF DEATH | MONTH | DAY | YEAR | 2b HOUR | | | |
| | RUTH M CORBIN | | | | 8 | 28 | 79 | | 1:30 PM | | | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | | | 6. AGE [IN YEARS LAST BIRTHDAY] | | | | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN | | |
| F | W | MONTH | DAY | YEAR | 86 | | | | | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b CITIZEN OF WHAT COUNTRY? | 8 | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | MD. | | | |
| Maryland | U.S. | MARRIED <input checked="" type="checkbox"/> | NEVER MARRIED <input type="checkbox"/> | WIDOWED <input checked="" type="checkbox"/> | DIVORCED <input type="checkbox"/> | WICOMICO | | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| SALISBURY, MD | RIVERWALK MANOR | | | | | Housewife | | | | | | |
| 13a STATE | 13b COUNTY | 13c CITY OR TOWN | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e STREET ADDRESS | | | | | | |
| Md | Somerset | Chance | | | | | | | | | | |
| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | | | MIDDLE | | | LAST | | | |
| Granville | | Webster | Lillie | | | Dashiell | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN | 16b SOCIAL SECURITY NO. | 17. INFORMANT Ruth Corbin pre-arranged | | | ADDRESS Chance, Md. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| NO | 214-36-5365 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost { DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes Mellitus</u> | | | | | | | | | | | | |
| 19a DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH [IF EITHER, NOTIFY MEDICAL EXAMINER] | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | | | CITY OR TOWN | COUNTY | STATE | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Aug 11</u> , 19 <u>76</u> , to <u>Aug 28</u> , 19 <u>79</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>Aug 28</u> , 19 <u>79</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Thomas C. Hill Jr. M.D.</u> | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> | MEDICAL DIRECTOR <input checked="" type="checkbox"/> | STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED <u>8/29/79</u> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Thomas C. Hill Jr</u> | 22e. ADDRESS <u>Pine Bluff Road, Salisbury, Md.</u> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL [SPECIFY] | 23b. DATE <u>8/31/79</u> | 23c. NAME OF CEMETERY OR CREMATORIUM <u>Buck Creek Cemetery</u> | | | 23d. LOCATION CITY OR TOWN <u>Chance, Somerset, Md.</u> | | | | | | COUNTY | |
| 24. FUNERAL DIRECTOR NAME <u>James L. Hinman</u> | ADDRESS <u>Pine Bluff Ave</u> | 25a. DATE REC'D. BY REGISTRAR <u>SEP 4 1979</u> | | | 25b. REGISTRAR'S SIGNATURE <u>Henry McBrady</u> | | | | | | | |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGES 1 AND 2 AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 21057 | |
|---|---------|--|------------------------------------|---|---|---|--------------------------|--------------------------------------|--------|-------------------------|------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF ESTI- DEATH MATED | | | MONTH | DAY | YEAR | 2b. HOUR | |
| ROBERTA | | | | | COVINGTON | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 8-1-79 | 19 | 6 | 35 M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YR. MONTHS DAYS | 8. IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD | | | MONTH | DAY | YEAR | 2d. HOUR | |
| Female | AA | 7 28 03 | 76 yrs. | | | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 8-1-79 | 19 | 11 | " | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| No. CAROLINA | | U.S.A. | | | | | | Wicomico | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Salisbury | | DOA Peninsula General Hospital | | | Recreation | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | MD. | | | |
| Md. | | Wicomico | | Salisbury | | Rt. 50 | | | | | | | |
| 14. FATHER'S NAME | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | ADDRESS | | LAST | | | |
| WILLIAM | | | | MARTIN | | ESTELLA | | SALEM | | INOKAM | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | BETWEEN ONSET AND DEATH | | | |
| NO | | | | 220-26-3224 | | PAULINE HARMON | | Rt 10 Shrub Hill | | Sudden | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Coronary Occlusion | | | | | | | | | | | | | |
| 410- Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (b) _____ | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | | | | |
| TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER | | | | | | | | | | | | | |
| DATE SIGNED 8-2-79 | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | 409 Camden Ave., Salisbury, Md. | | | | | | | | | | | |
| EXAMINER'S ADDRESS | | | | | | | | | | | | | |
| 22b. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN | | 23d. LOCATION CITY OR TOWN | | 23e. COUNTY | | 23f. STATE | | | |
| Burial 8-5-79 | | | | Burial Home, Md. | | Burial Home, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. DATE REC'D. BY REGISTRAR | | 25c. REGISTRAR'S SIGNATURE | | | | | |
| West-Fooks Funeral Home, Salisbury, Md. | | | | AUG 6 1979 | | | | | | | | | |

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RECORDED X AND COPIED 2 MARCH 1973 BY J. H. TAYLOR

RECORDED X AND COPIED 2 MARCH 1973 BY J. H. TAYLOR

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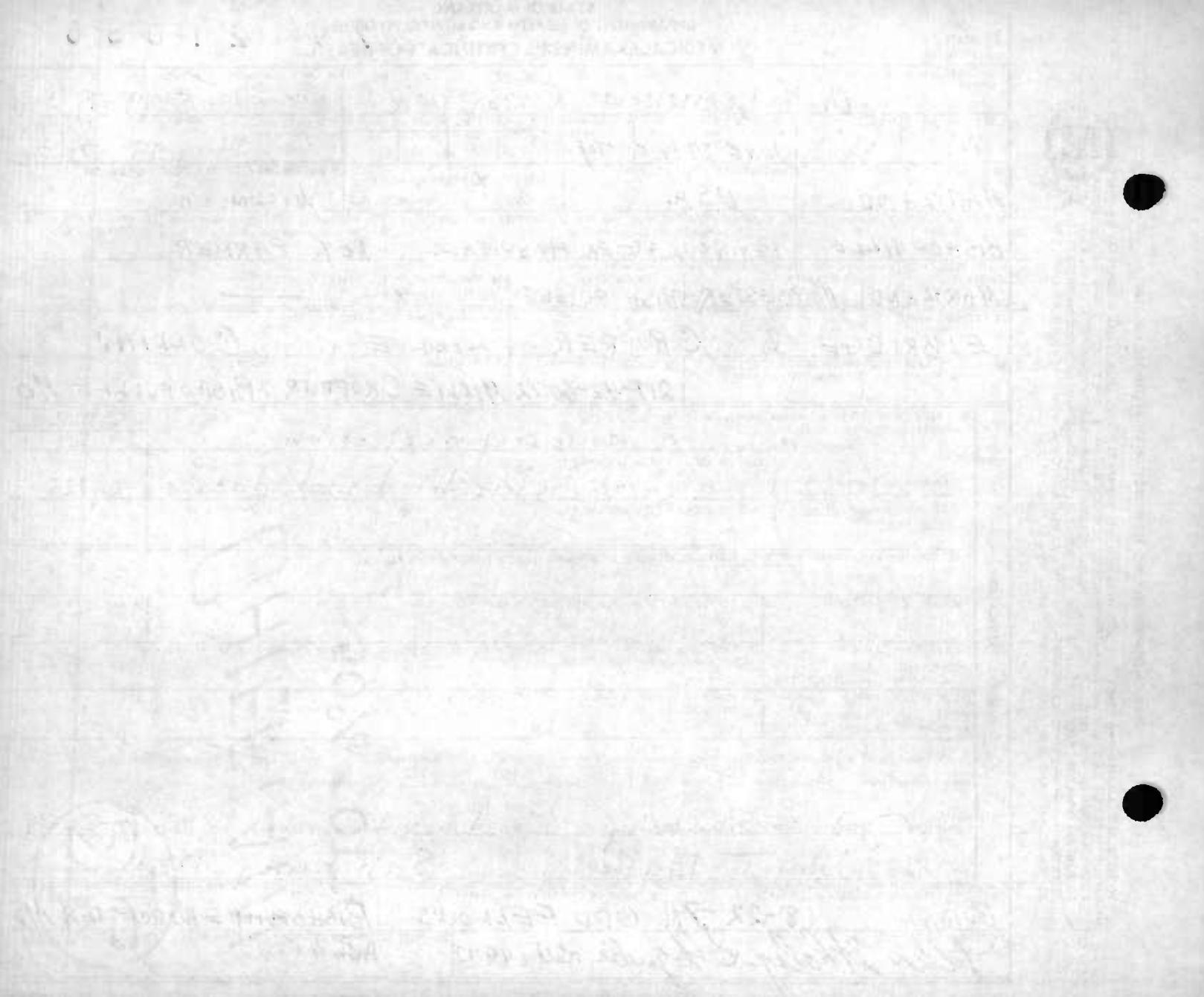
PT-3-6

RECORDED X AND COPIED 2 MARCH 1973 BY J. H. TAYLOR

RECORDED X AND COPIED 2 MARCH 1973 BY J. H. TAYLOR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING". GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 21058 | | | | |
|--|--|-------------------------------------|---|---|-------------------------------|---|--|---------------------------------|---|---------------------------------|--|--|--|-----------|--|--|
| 1- STATE REGISTRAR | | | I. DECEASED NAME FIRST MIDDLE LAST | | | | | | | | | 2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED <input type="checkbox"/> 8-19 1979 | | | 2b. HOUR 5:35 PM | |
| | | | J. Warren Cropper | | | | | | | | | | | | | |
| 3 SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7 IF UNDER 1 yr. MONTHS DAYS | | 8 IF UNDER 24 HRS. HOURS MIN | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR DEAD Aug 19 1979 | | | 2d. HOUR 5:35 PM | |
| J. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH BISHOPVILLE | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PENINSULA GEN HOSPITAL. | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. FARMER | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MARYLAND | | | 13b. COUNTY WORCESTER | | 13c. CITY OR TOWN BISHOPVILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | | | | | | |
| 14. FATHER'S NAME ELBRIDGE | | | MIDDLE J. | | LAST CROPPER | | 15. MOTHER'S MAIDEN NAME LILLIE | | 16. ADDRESS COLLINS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 217-42-6072 | | | HILLIE CROPPER BISHOPVILLE MD | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 410- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. IMMEDIATE CAUSE (a) coronary occlusion DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease 4 yrs DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | 20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY | | STATE | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | TITLE (SPECIFY) ACTUAL SIGNATURE John T Bulkeley M.D. Deputy MEDICAL EXAMINER | |
| EXAMINER'S NAME (TYPE OR PRINT) John T Bulkeley ADDRESS Salisbury, Md. | | | | | | | | | | | | | | | DATE SIGNED 8-20-79 | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | | 23b. DATE 8-22-79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL ODD FELLOWS | | | 23d. LOCATION CITY OR TOWN BISHOPVILLE | | | COUNTY NORCESTER | | STATE MD. | | |
| 24. FUNERAL DIRECTOR Peter Whaley, Salisbury, Md., 19973 | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR AUG 27 1979 | | | 25b. REGISTRAR'S SIGNATURE | | | | |

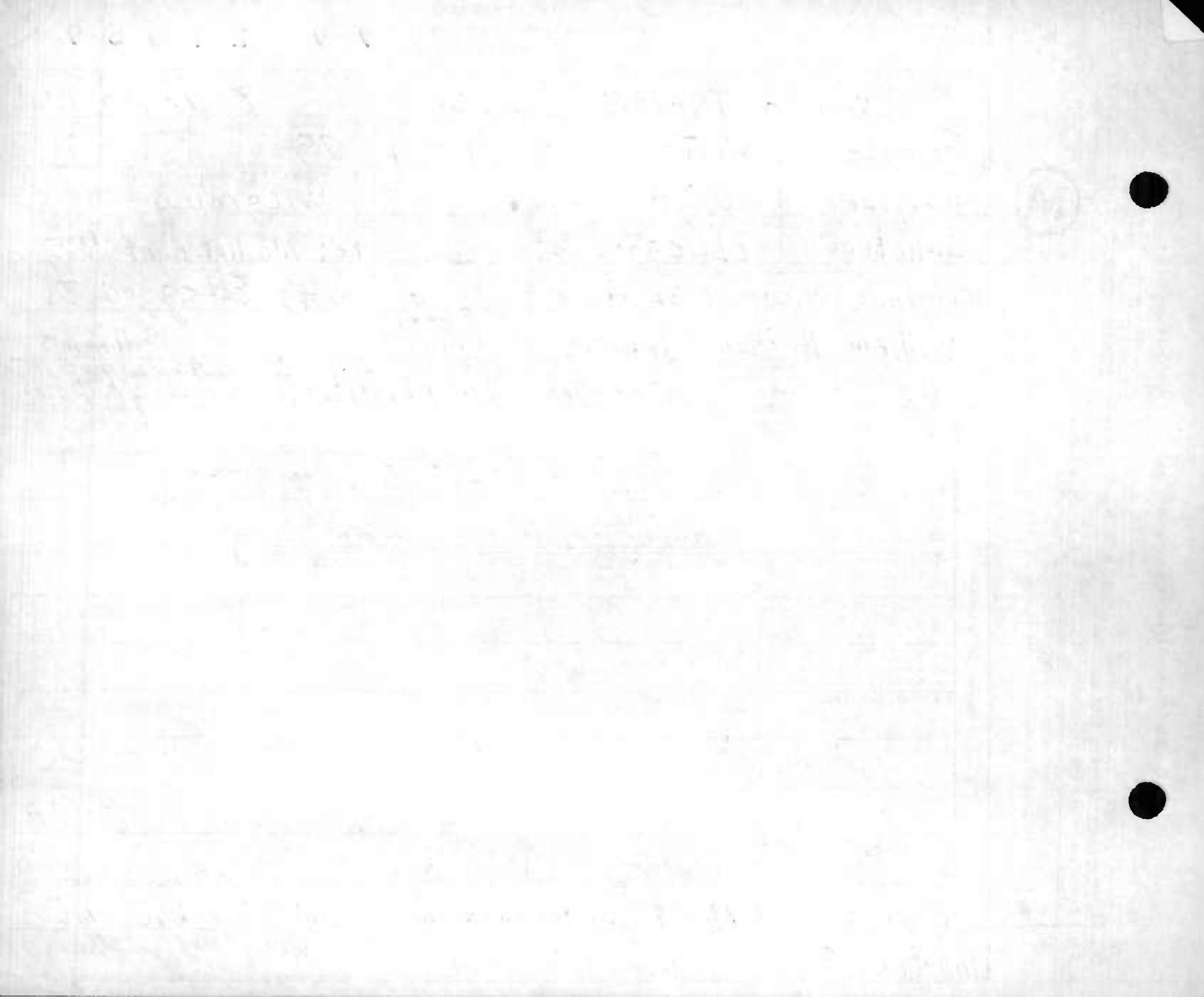


TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 9 21059 | | |
|---|--|------------------------------|---|---|-------------------|---|---|--|--|--|---|--------------------------------------|-------|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR | | | | | | | | |
| WILLA TRAVERS Culver | | | | | | 8 16 1979 9:30 P.M. | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | | | |
| Female | | White | | 2 14 1904 | | | 75 | | | YRS. | | | | |
| 7a. BIRTHPLACE COUNTRY | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | | |
| Maryland | | U.S.A. | | | | | Wicomico | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Salisbury | | | Ellwood St | | | | | | Ret. Md-Nat. Bank Book keeper | | | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | Rt #5 Ellwood St | | | |
| Maryland | | | Wicomico | | Salisbury | | NO | | Rt #5 | | Salisbury Md 21801 | | | |
| 14. FATHER'S NAME | | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | | William | | | | |
| William Hudson | | | | | Travers | | Carrie | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | | |
| No | | | 215-18-1568 | | | MARY L. Niblett | | | Rt #5 Ellwood St Salisbury Md 21801 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 10, 1b, and 1c) PART I. DEATH WAS CAUSED BY: | | | IMMEDIATE CAUSE (a) Cardiac arrest 1830 DUE TO, OR AS A CONSEQUENCE OF (b) Disseminated Adenocarcinoma Jovay Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| | | | DUE TO, OR AS A CONSEQUENCE OF (c) mucous cyst of adenocarcinoma Jovay | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | COUNTY | STATE | | |
| 22a. I certify that (I this hospital) attended the deceased from 6/26/78 to 8/16/79, and that in my (our) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on 8/15 19 79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I we) did/did not view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| Philip A Insley | | | | | | MD | | | | | | 8/21/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | Medical Center Salisbury, Md | | | | | |
| Philip A Insley | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIUM | | | 23d. LOCATION CITY OR TOWN | | | COUNTY | STATE | |
| Burial | | | 8/19/1979 | | | Wicomico Mem Park | | | Salisbury Wic | | | Md | | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Hill-Baker-Bounds | | | Salisbury, Md 21801 | | | AUG 23 1979 | | | John McReady | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical Examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 9 | 2 | 1 | 0 | 6 | 0 | |
|---|--|-------------|--|-------------------|--|--|--|--|---|--|--|---|-----|------------------|----------|--|
| | | | | | | | | | | REG. NO. | | | | | | |
| 1. FOR STATE REGISTRAR | | | 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | |
| | | | CHARLES TILDON | | | DASHIELL JR | | | AUGUST 20 1979 | | | 9 | 55 | M | 9 55 M | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 14 DAYS | | |
| Male | | | White | | | MONTH April DAY 25, 1916 YEAR | | | 63 | | | MONTHS | | DAYS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | 10. CITY OR TOWN OF DEATH | | | | |
| Quantico, Md. | | | USA | | | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | Wicomico | | | Salisbury | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | | |
| Peninsula General Hospital | | | | | | | | | | Salesman Candy product | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS | | | 14. FATHER'S NAME | | | | |
| Maryland | | Wicomico | | Salisbury | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | PineKnoll Terrace | | | FIRST MIDDLE LAST | | | | |
| Charles Tildon Dashiell | | | Sr. Carrie Rencher | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | | ADDRESS | | | | | | |
| Yes | | | WW II 220-10-8498 | | | Mrs. Irene L. Dashiell same as 13 (wife) | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| IMMEDIATE CAUSE 1a. Obstructive Jaundice 1629 Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last. | | | | | | | | | | 24 hrs | | | | | | |
| 1b. metastatic carcinoma of lung. DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | 6 months. | | | | | | |
| 1c. | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 7-23 1979 to 8-20 1979, that (2) we lost the deceased alive on 8-20 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated in my (our) opinion death occurred on the date and hour and from the causes stated in my (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Roger C Merrill | | | | | | | | | | 22c. DATE SIGNED 8-20-79 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | |
| ROGER C MERRILL | | | KAY AVE SALISBURY MD. 21801 | | | MD | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial | | | 23b. DATE 8/22/79 | | | 23c. NAME OF CEMETERY OR CREMATORIUM Wicomico Mem. Park | | | 23d. LOCATION CITY OR TOWN Salisbury, Wic., Md. | | | COUNTY | | STATE | | |
| 24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md. | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR AUG 23 1979 | | | 25b. REGISTRAR'S SIGNATURE John McBrady | | | | | | | |

cohort

Indigenous (aboriginal) population - unadjusted

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

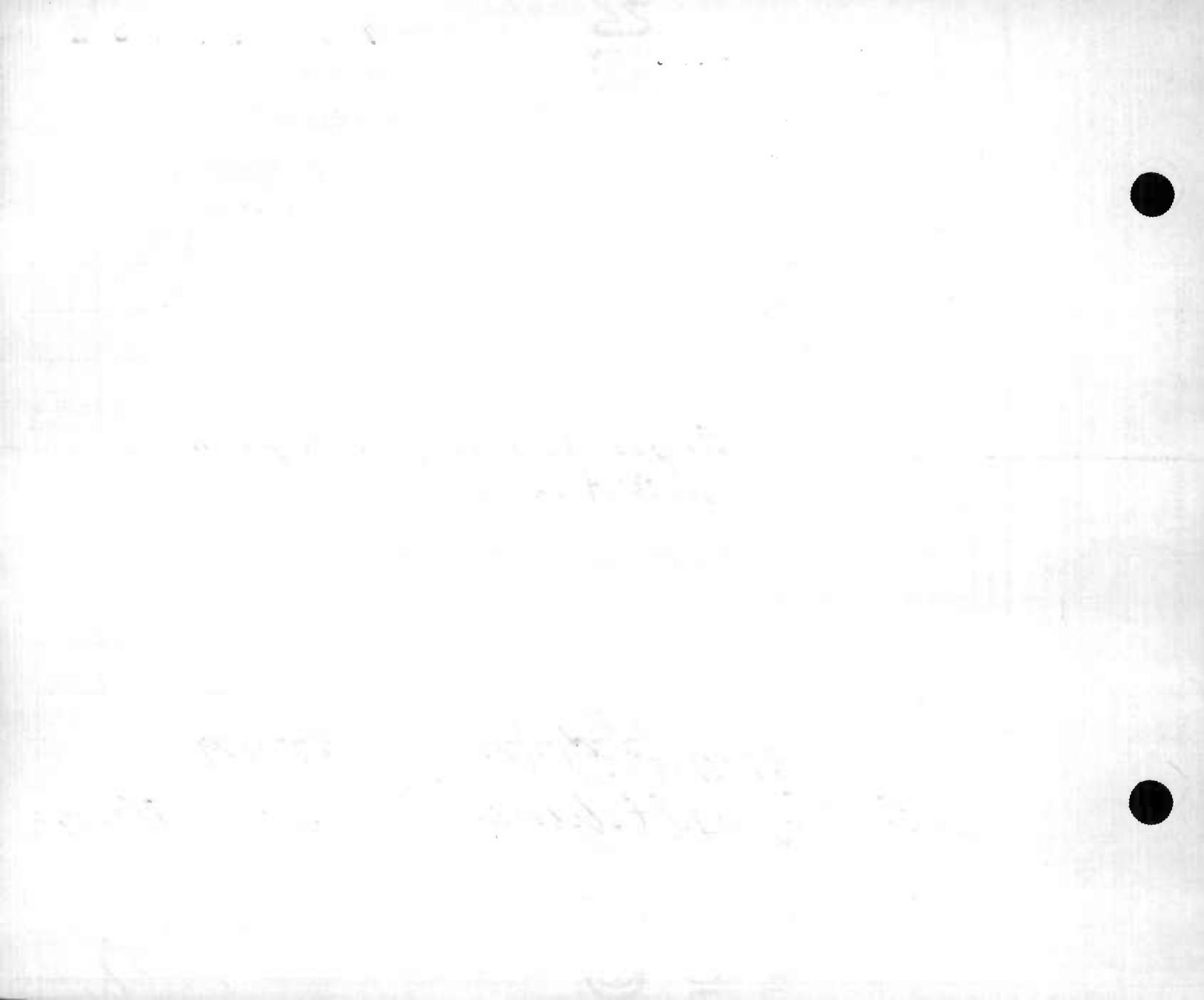
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. | | | |
|---|--|--|---|--------|-------|--|--|--|---|-----|------|--|------|-----------------|--|
| 1 - STATE REGISTRAR | | | 9 2 1 0 6 1 | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | | | |
| Charles | | | Franklin | | David | August 28, 1979 | | | | | | 1 P.M. | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | | |
| M | | | W | | | MONTH DAY YEAR | | | 65 | | | MONTHS | DAYS | IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | YRS. | | | |
| Delaware | | | U.S.A. | | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | Wicomico | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Salisbury | | | Peninsula General Hospital | | | Laborer | | | Gas Station | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | | | | |
| Maryland | | | Wicomico | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 916 S. Division St. | | | | | | |
| 14. FATHER'S NAME | | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | | 16. ADDRESS | | | | | | |
| Charles | | | | | David | Ruth | | | Fruitland, Md. 21826 | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | 18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| | | | 222-09-9495 | | | Ruth McCann Box 62 Bonach Trailer Ct | | | Massive Myocardial Infarction | | | | | | |
| 18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | 410- | | | DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 19. MEDICAL CERTIFICATION | | | Chronic Obstructive lung Disease | | | 20a. DATE OF OPERATION | | | 20b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20c. AUTOPSY? | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | BENITO S. CHAN MD | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | BENITO S. CHAN | | | 22e. ADDRESS | | | 547-D Riverside Drive | | | 8/28/79 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION CITY OR TOWN | | | COUNTY STATE | | | |
| Cremation | | | 9-1-1979 | | | Delmarve Crematory Lewes | | | Delaware | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| Holloway Funeral P.A. | | | Salisbury, Maryland | | | SEP 4 1979 | | | Larry Kelley | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 2 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. | | | | | |
|--|--|--|--|--|--|-------------------------------|---|-----------------------------------|--|-------|--|---|-----------------|----------|--|--|--|
| 1. DECEASED NAME | | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | | MONTH | DAY | YEAR | 2b. HOUR | | | |
| Emma | | | | Elizabeth Davis | | | 8-30-79 | | | | 3:40 PM | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | |
| Female | | White | | 11/15/1900 | | | 78 | | | | MONTHS | | DAYS | | | | |
| YRS. | | | | | | | | | | HOURS | | MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | MD. | | | | | | |
| Manticoke, Md. | | USA | | | | | Wicomico | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Salisbury | | Wicomico Nursing Home | | | | | | Saleslady & Cashier - Shoes | | | | | | | | | |
| USUAL RESIDENCE IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION | | | | | | | | | | | | 13a. STATE | | | | | |
| | | | | | | | | | | | | 13b. COUNTY | | | | | |
| | | | | | | | | | | | | 13c. CITY OR TOWN | | | | | |
| | | | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| | | | | | | | | | | | | 13e. STREET ADDRESS | | | | | |
| | | | | | | | | | | | | 521 Alabama Ave. | | | | | |
| 14. FATHER'S NAME | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | | | 16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| James | | A. | | White | Alice | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT (daughter) ADDRESS | | | | Rt. 3, | | | | | | | | | |
| No | | 220-10-9506 | | Mrs. Nelda D. Guthrie, Salisbury, Md. | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| IMMEDIATE CAUSE (a) 1719 <i>Angio Sarcoma & widespread</i> | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Mitrafus -</i> | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | |
| 19a. MEDICAL CERTIFICATION | | | 19b. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDECAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | | | CITY OR TOWN | | COUNTY | | STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/13/79, 19, to 8/20/79, 19, that (I) (we) last saw the deceased alive on 8/18/79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | 22b. SIGNATURE <i>A. C. Mitchell, M.D.</i> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 8/31/79 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | Fruitland, Md. | | | | | | | | | | |
| A. C. Mitchell, M.D. | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION CITY OR TOWN | | COUNTY | | STATE | | | | | | |
| Burial | | 9/3/79 | | Parsons Cemetery | | | Salisbury, Wic., Maryland | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| HOLLOWAY FUNERAL HOME, Salisbury, Md. | | | | | | SEP 6 1979 | | <i>Holloway Holloway</i> | | | | | | | | | |



10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 21063 |
|---|--|--|---|--|--|--|--|--|--|--|--|----------------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE | | | 2d. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | | |
| EUNICE BRITTINGHAM DENNIS | | | | | | AUGUST 15 1979 | | | 2 53 P.M. | | | |
| 3. SEX Female | | | 4. RACE White | | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | |
| | | | | | | JULY 4 1920 | | | 59 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 8. BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | 12e. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sec. SALISBURY STATE College | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MARYLAND | | | 13b. COUNTY Wicomico | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 823 EAST Church St. | | | |
| 14. FATHER'S NAME George HANDY BRITTINGHAM | | | | | | 15. MOTHER'S MAIDEN NAME Blanche | | | 16. ADDRESS 823 E Church St. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 217-07-7473 | | | 17. INFORMANT George F. DENNIS SALISBURY, MD 21801 | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH six weeks | | | |
| 18. CAUSE OF DEATH: (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Caducosity anest</u> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF b) <u>increased intracranial pressure</u> 6 weeks | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF c) <u>thalamic glioma</u> 3 weeks | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>were</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION <u>none</u> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>65-15</u> 1979 to <u>8-15</u> 1979, that (I) (we) last saw the deceased alive on <u>8-15</u> 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <u>James Wilson Spence</u> | | | 22c. DEGREE M.D. | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d. DATE SIGNED 8/15/1979 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 8/18/1979 | | | 23c. NAME OF CEMETERY OR CREMATORIAL PARSONS Cemetery | | | 23d. LOCATION CITY OR TOWN SALISBURY WIC. MD. | | | |
| 24. FUNERAL DIRECTOR NAME Hill-Baker-Bounds | | | ADDRESS SALISBURY, MD. | | | 25a. DATE REC'D. BY REGISTRAR AUG 21 1979 | | | 25b. REGISTRAR'S SIGNATURE Linton Melody | | | |

11/20/04

Testimony before Senate Committee on Budget

Senate Budget Committee

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 9 2 1 0 6 4 | |
|---|--|------------------------------|---|---|------|--|--|--|---|---------------------|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 20. DATE OF DEATH | | | MONTH | DAY | YEAR | 26. HOUR | |
| Arthur (none) | | | | | DIX | AUGUST 18 | | | 1979 | | | 3 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 16. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 24 HRS | | | |
| Male | | White | | July 2-1909 | | | 70 | | | MONTHS | YEARS | IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Virginia | | U.S.A. | | | | | Wicomico | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Salisbury | | | Peninsula General Hospital | | | | | | Waiterman | | | Seafood | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | MD. | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | |
| Virginia | | Northampton | | Cape Charles | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | Mason Ave. | | | |
| 14. FATHER'S NAME | | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | | FIRST | MIDDLE | LAST | | |
| Arthur (none) | | | | | Dix | Mary | | | | | Tyler | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| no | | | 227 10 5188 | | | Warren Dix | | | Cape Charles, Va. 23310 | | | 1 day | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | | | | | | | 2 days | |
| 4409 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. | | | | | | | | | | | | 3 years - | |
| DO TO, OR AS A CONSEQUENCE OF (b) Massive Vascular thrombosis, legs | | | | | | | | | | | | | |
| DO TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic occlusive disease | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| 8/11/79 | | | Thrombosis, leg grafts + arteries | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | | P.M. 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | COUNTY | STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/11 1979 to 8/12 1979, that (I) (we) last saw the deceased alive on 8/12 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DEGREE | | | | | | 22d. DATE SIGNED | | | | |
| William P. Sadler | | | MD | | | | | | 8/14/79 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | |
| William P. Sadler | | | S. Division Street, Salisbury, Md. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION CITY OR TOWN | | | 23e. COUNTY STATE | |
| Burial | | | Aug. 14, 1979 | | | Cape Charles | | | Cape Charles | | | Va. | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 23310 | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | |
| N. Fat | | | Fat & Scott Cape Charles, Va. | | | | | | AUG 23 1979 | | | H. Murphy | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 9 2 1 0 6 5 | |
|--|--|--|---|--|--------------------------------------|---|---------------------------------------|--|--|-------------------------------------|-------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR 5 ¹⁵ P.M. | |
| William Frederick Dooley | | | | | Dooley | August 26 1979 | | | | | | | |
| 3. SEX Male | | | 4 RACE Caucasian | 5. DATE OF BIRTH Month Day Year April 4 1920 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 | | | IF UNDER 1 YEAR YRS. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE COUNTRY Vermont | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | 12a. USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE Field Representative Tax Collection | | | 12b. KIND OF BUSINESS OR INDUSTRY Md. | | | | |
| 13a. STATE Md | | | 13b. COUNTY Prince Georges | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 9214 Tuckahoe Lane | | | | |
| 14. FATHER'S NAME William Francis Dooley | | | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME Caroline | 16. SOCIAL SECURITY NO. W.N.I.I., Korea 008-10-5995 | | | 17. INFORMANT Mrs. Virginia Dooley, 9214 Tuckahoe Lane | | | ADDRESS Adelphia, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | DUE TO, OR AS A CONSEQUENCE OF b) <i>cardiac fibrillation</i> | | | DUE TO, OR AS A CONSEQUENCE OF c) <i>arterial occlusion</i> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Day | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Hypertension</i> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | COUNTY | STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/20/79</i> to <i>8/21/79</i> , that (I/we) last saw the deceased alive on <i>8/20/79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>John G. Green</i> | | | 22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d. ADDRESS Ohio Ave. Salisbury, Md. | | | 22e. DATE SIGNED <i>8/26/79</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 8/30/79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cem. | | | 23d. LOCATION CITY OR TOWN SilverSprings Mont. Co. Md. | | | | |
| 24. FUNERAL DIRECTOR NAME Anne R. Bushay | | | ADDRESS 108 Williams St., Berlin, Md. | | | 25a. DATE REC'D. BY REGISTRAR AUG 28 1979 | | | 25b. REGISTRAR'S SIGNATURE <i>Patsy McHenry</i> | | | | |

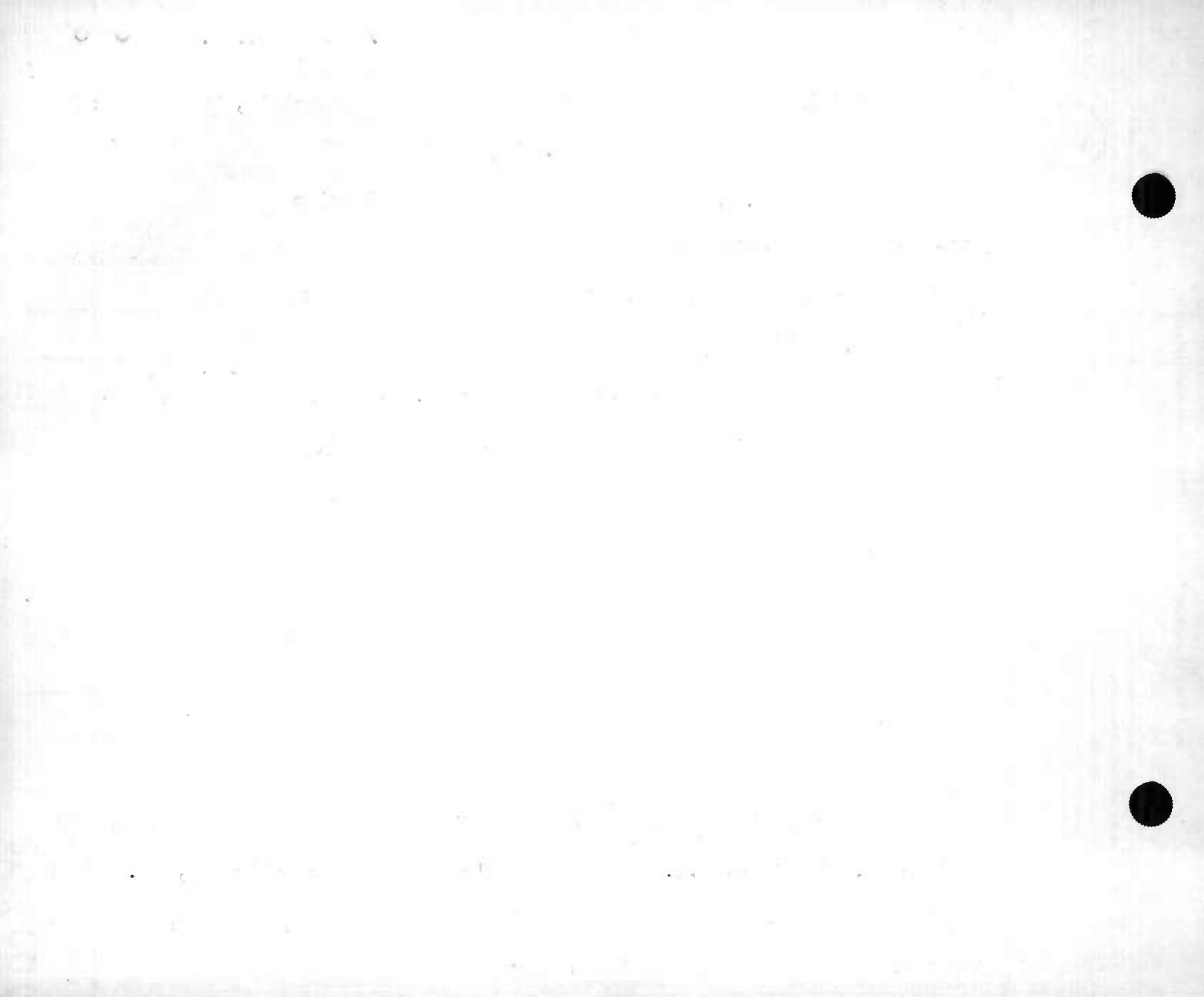
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | | |
|---|--|---|----------------------------------|---|--|------------------------|---|--|---------------------|---|------------------------|--|---------|--|
| 1 - STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | | | 2b. HOUR | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | August 18, 1979 | | | | | | | 9:40 AM | |
| Orville KENNETH DULIN | | | | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| male | | caucasian | | Mar. 16, 1902 | | | 77 | | YRS. | | MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Maryland | | U.S. | | | | | Wicomico | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Salisbury | | Deer's Head Center | | parts clerk | | | manufacture | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | | |
| Maryland | | Queen Anne | | Stevensville | | | YES <input checked="" type="checkbox"/> | | Main Street | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | | | | |
| Harry D. Duline | | Bessie Kennard | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | ADDRESS | | | | | | | |
| no | | 195-05-9975 | | Thelma D. Vaughn | | | R.D. #3, Bx 786 Easton, Md. 21601 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | | |
| 4292 DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | 22c. DATE SIGNED | | | | | | | | | |
| Edward P. Ritchings, M.D. | | | | | 6/18/79 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | | |
| Edward P. Ritchings, M.D. | | Deer's Head Center; Salisbury, Md. 21801 | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8-21-1979 | | 23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill | | | 23d. LOCATION CITY OR TOWN Easton, Talbot, Maryland | | COUNTY | | STATE | | | |
| 24. FUNERAL DIRECTOR NAME Newnam Funeral Home | | ADDRESS Easton, Md. | | 25a. DATE REC'D. BY REGISTRAR AUG 21 1979 | | 25b. MEDICAL SIGNATURE | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

Page _____

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. 9 21067 |
|--|-----------|--|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2. DATE OF DEATH | | 2b. HOUR 23 |
| Nina Marfield Dyles | | | AUGUST 29 1979 | | TA M |
| 3. SEX F | 4. RACE W | 5. DATE OF BIRTH MONTH 4 DAY 29 YEAR 1901 | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO | |
| 10. CITY OR TOWN OF DEATH SALISBURY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PENINSULA GENERAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Fruitland | |
| 14. FATHER'S NAME FIRST David | | MIDDLE | | 15. MOTHER'S MAIDEN NAME FIRST Amelia | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 214-32-5596 | | 17. INFORMANT ADDRESS Mrs. Mary A. Poso Salisbury, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 1949 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Breast Cancer DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) this hospital attended the deceased from 8/28 1979 to 8/29 1979, that (I) (was) (not) lost saw the deceased alive on 8/28 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE John Grasso | | 22c. DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22d. DATE SIGNED 8-30-79 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John A Grasso | | 22e. ADDRESS PGHMC SALISBURY MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-1-79 | | 23c. NAME OF CEMETERY OR CREMATORIAL Springfield Gardens | |
| 24. FUNERAL DIRECTOR NAME Holloway Funeral Home P.A. Salisbury, Md. | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR SEP 4 1979 | 25b. REGISTRAR'S SIGNATURE Henry McElroy |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 9 2 1 0 6 8 | |
|---|--|---|---|--|--|--|---|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR August 17 1979 | | | | | | | | | 2b. HOUR 9:40 PM | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST WILMER ALLEN | | | LAST Dykes | | | 5. DATE OF BIRTH MONTH Dec. DAY YEAR 27, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 | | IF UNDER 1 YEAR MONTHS 0 YRS. DAYS 0 HOURS 0 MIN. 0 | |
| 3. SEX Male | | 4. RACE White | | | 7. CITIZEN OF WHAT COUNTRY? USA | | | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY Farming | | | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 519 Dykes Road | | | | | |
| 14. FATHER'S NAME FIRST Ernest P. MIDDLE Dykes LAST | | | | | 15. MOTHER'S MAIDEN NAME .Caroline | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 217-14-8305 | | | 17. INFORMANT Mrs. Nina P. Dykes (wife) same as 13 | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial infarction & Shock | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | | | |
| { DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-17, 1979, to 8-17, 1979, that (I) (we) last saw the deceased alive on 8-17, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE EJ Colwell | | 22c. DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d. DATE SIGNED 8-17-79 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Colwell | | 22e. ADDRESS PGH, Salisbury MD 21801 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8/21/79 | | 23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park | | | 23d. LOCATION CITY OR TOWN Salisbury, Wic., Maryland | | | | | | |
| 24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Maryland | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR AUG 22 1979 | | | 25b. REGISTRAR'S SIGNATURE Firley McCarty | | | | | |
| DHMH-16 50M7/77 (VR A 15 (4)) | | | | | | | | | | | | | |

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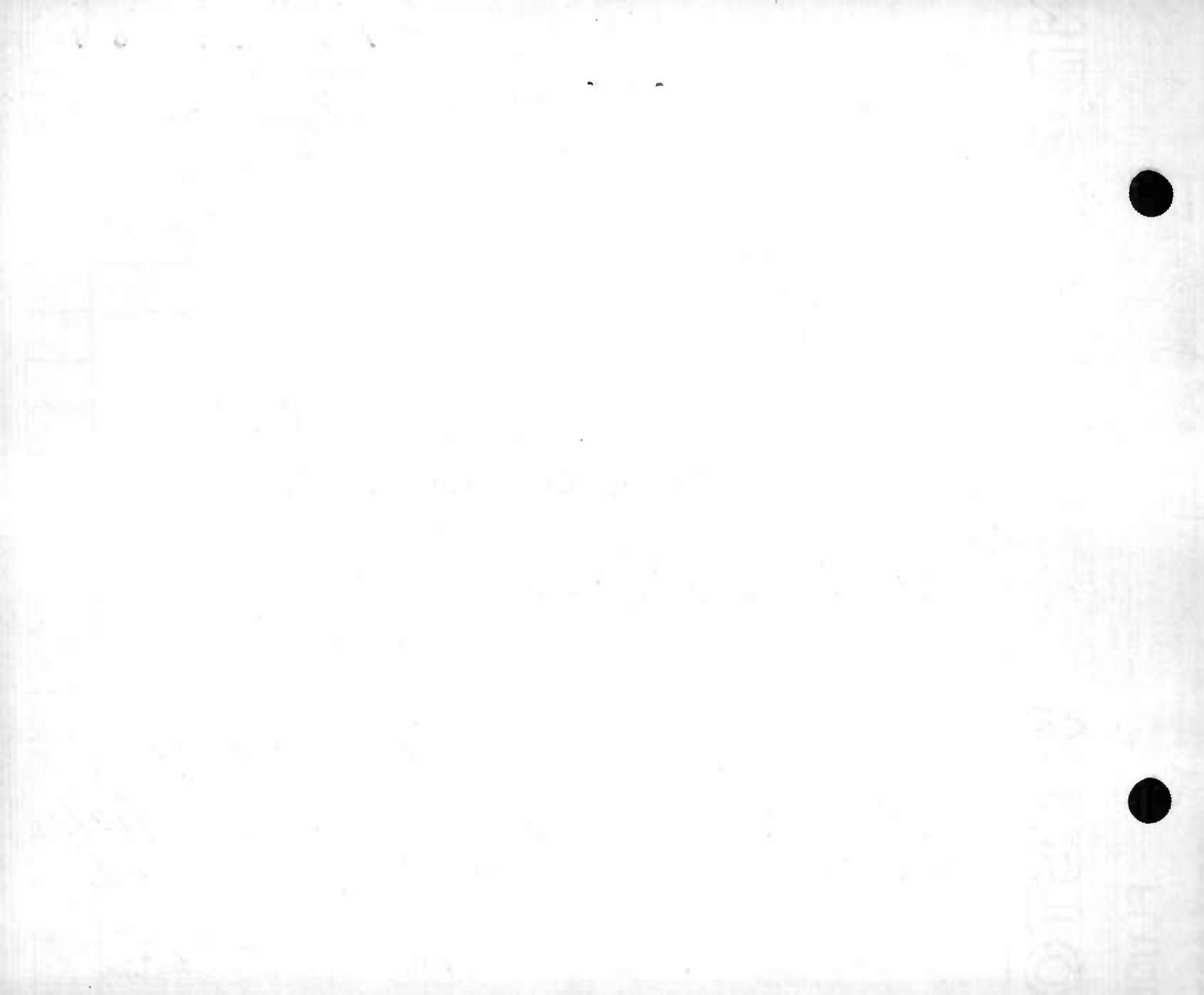
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removals.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or one of the following forms must be completed and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removals.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. | | | |
|--|---|---|--|--|---|--|-----------------------------------|-------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | |
| Edythe C. FEASTER | | | 8 | - 12 | 79 | 1069 | 102 noon | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN | |
| F | W | 6 6 93 | 86 yrs | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | |
| Townsend, Md. | USA | | | WICOMICO | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Salisbury | Wicomico Nursing Home | | | Housewife | | | none | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13a. STREET ADDRESS | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 2214 Charleston Place | | | |
| Maryland | Pr. George | Hyattsville | Bertha E. Ward | | | | | |
| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | | LAST | | | |
| Samuel | F. | Cooke | Bertha | | E. Ward | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | |
| No | | | | (son) Mr. Rexford H. Feaster, Princess Anne, Md. | | Rt. 1, Box 306 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arterosclerosis. | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Carcinoma of bladder & metastasis | | | | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | | | CITY OR TOWN | COUNTY | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-16, 1979, to 8-12, 1979, that (I) (we) last saw the deceased alive on 8-8, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE A.C. Mitchell MD | | | | | DEGREE | 22c. DATE SIGNED 8/13/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.C. Mitchell | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | 23c. NAME OF CEMETERY OR CREMATORIAL Arlington National | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
| 24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md. | | | | | 25a. DATE REC'D. BY REGISTRAR AUG 16 1979 | 25b. REGISTRAR'S SIGNATURE Lillian McCreary | | |
| ADDRESS | | | | | | | | |
| DHMH-16 20M (VRA 15, 4) 7/78 | | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PRINT IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 5 FOR YOUR FILE.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 21070 | |
|---|---------|--|------------------------------------|--------------------------------------|---|---|--|--------------------------------------|----------|--------------------------------------|---------------------|----------------|---|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF ESTI- MATED | | | MONTH | DAY | YEAR | 2b. HOUR | |
| DAVID K. FINKELSTEIN | | | | | | <input checked="" type="checkbox"/> | <input type="checkbox"/> | 8-10-79 | 12:20A | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YR. MONTHS DAYS | 8. IF UNDER 24 HRS. HOURS MIN | 2c. DATE PRONOUNCED DEAD | | | MONTH | DAY | YEAR | 2d. HOUR | |
| Male | White | Sept 21 1933 | 45 yrs. | | | <input checked="" type="checkbox"/> | <input type="checkbox"/> | 8-10-79 | 19 | 11 | M | | |
| 7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | | | Wicomico County | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Salisbury | | Peninsula General Hospital | | | | | Teacher | | | Balt. City | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | | |
| Md. | | | | Baltimore | | | | 3510 Ellerslie Ave. | | | | | |
| 14. FATHER'S NAME FIRST | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME FIRST | | MIDDLE | | | LAST | | |
| David | | | | Finkelstein | | Margaret | | | | | Eser | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Mother: ADDRESS | | | Balt., Md. 21218 | | |
| Yes | | | | 215-34-1872 | | | | Margaret Finkelstein | | | 3510 Ellerslie Ave. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 410- Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | minutes |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? | | | | | | |
| | | | | | | | <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D. ADDRESS 109 Camden Ave., Salisbury, Md. | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION CITY OR TOWN | | COUNTY | | STATE | | |
| Burial | | Aug 21 1979 | | Moreland Memorial | | | Baltimore | | Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| Leonard J. Ruck, Inc. | | Baltimore, Maryland | | AUG 13 1979 | | | Lester Royer | | | | | | |
| DHMH - 17 (VR A15 ME (5)) 30M 7/73 | | | | | | | | | | | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 21071

| | | | | | | | | | | | | | | | |
|--|--|--|--|--|------------------------------|--|--|---|--|--------------------------------------|--|--|---|--|--|
| 1- FOR STATE REGISTRAR | | | 2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED <input type="checkbox"/> 8 4 1979 2b. HOUR M 3:03 P.M. | | | | | | | | | | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST James J. Fromm | | | 2c. DATE PRONOUNCED MONTH DAY YEAR DEAD <input type="checkbox"/> 8 4 1979 2d. HOUR 3:53 P.M. | | | | | | | | | | | | |
| 3. SEX M 4. RACE white 5. DATE OF BIRTH MONTH DAY YEAR 9 25 05 73 6. AGE (IN YEARS) LAST BIRTHDAY 73 YRS. | | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | | 7b. CITIZEN OF WHAT COUNTRY? US | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula Gen'l Hosp | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auto dealer | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Virginia | | | 13b. COUNTY Northampton | | 13c. CITY OR TOWN Machipongo | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS US RTE. 13 23405 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Fromm | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Romie | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Unknown | | | 16b. SOCIAL SECURITY NO. 207-01-1228 | | | | | 17. INFORMANT ADDRESS Grace Siegfried Fromm, Machipongo, Va 23405 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Skull DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR P.M. 8 4 1979 | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Passenger Auto Accident | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Hwy | | | | | 21f. LOCATION STREET RT 13 CITY OR TOWN Oak Hall COUNTY Accomac STATE Va | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Earl L. Royer | | | TITLE (SPECIFY) M.D. Deputy | | | | | MEDICAL EXAMINER | | | | | DATE SIGNED 8-4-79 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer | | | ADDRESS Salisbury, Md | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 8/8/79 | | | | | 23c. NAME OF CEMETERY OR CREMATORIAL Easton, Pa. | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| 24. FUNERAL DIRECTOR James N. Fox | | | ADDRESS Temperanceville, Va. | | | | | 25a. DATE REC'D. BY REGISTRAR AUG 13 1979 | | | | | 25b. REGISTRAR'S SIGNATURE Jerry McElroy | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 21072

| | | | | | | | | | | | | | | |
|---|--|-------------------------|--|---|--|---|---|--------------------------|--|---|----------------------------------|---------------------|--|--|
| 1- STATE REGISTRAR | | | 2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED <input type="checkbox"/> 8-31-79 8:50P M | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MOIR M. | | | LAST FULKS | | | 2b. HOUR MONTH DAY YEAR 11 M | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR 6 12 17 | | | 6. AGE (IN YEARS) LAST BIRTHDAY 62 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN | | | |
| Male | | White | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOA Peninsula General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contract Manager | | | 12b. KIND OF BUSINESS OR INDUSTRY Bus. Machines | | | | | |
| 13a. STATE Md. | | | 13b. COUNTY Worcester | | 13c. CITY OR TOWN Ocean City | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 902 Blue Water E., 134th St. Coastal Highway | | | | | |
| 14. FATHER'S NAME B. Friel | | | 15. MOTHER'S MAIDEN NAME Frances Hawks | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. W.W.II 579-18-5705 | | | 17. INFORMANT Mrs. Mary J. Fulks | | | ADDRESS 902 S. Blue Water E., 134th St. Coastal Hwy | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 410- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b). | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Deputy</i> | | TITLE (SPECIFY) M.D. | | | MEDICAL EXAMINER | | | DATE SIGNED 9-4-79 | | | | | | |
| | | | | | | | | | | EXAMINER'S NAME (TYPE OR PRINT) | | Earl L. Royer, M.D. | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | Earl L. Royer, M.D. | | | ADDRESS 409 Camden Ave., Salisbury, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 9/4/79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park | | | 23d. LOCATION CITY OR TOWN Berlin R.F.D., Wor. | | COUNTY Md. | | | |
| 24. FUNERAL DIRECTOR NAME <i>A. Burbage</i> Burbage Funeral Home, Berlin, Md. | | | ADDRESS 108 Williams St. | | | 25a. DATE REC'D. BY REGISTRAR SEP 7 1979 | | | 25b. REGISTRAR'S SIGNATURE <i>Larry Royer</i> | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEFICIENCY IS FOUND, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 1b, GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PA, RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL CREMATION, OR REMOVAL.



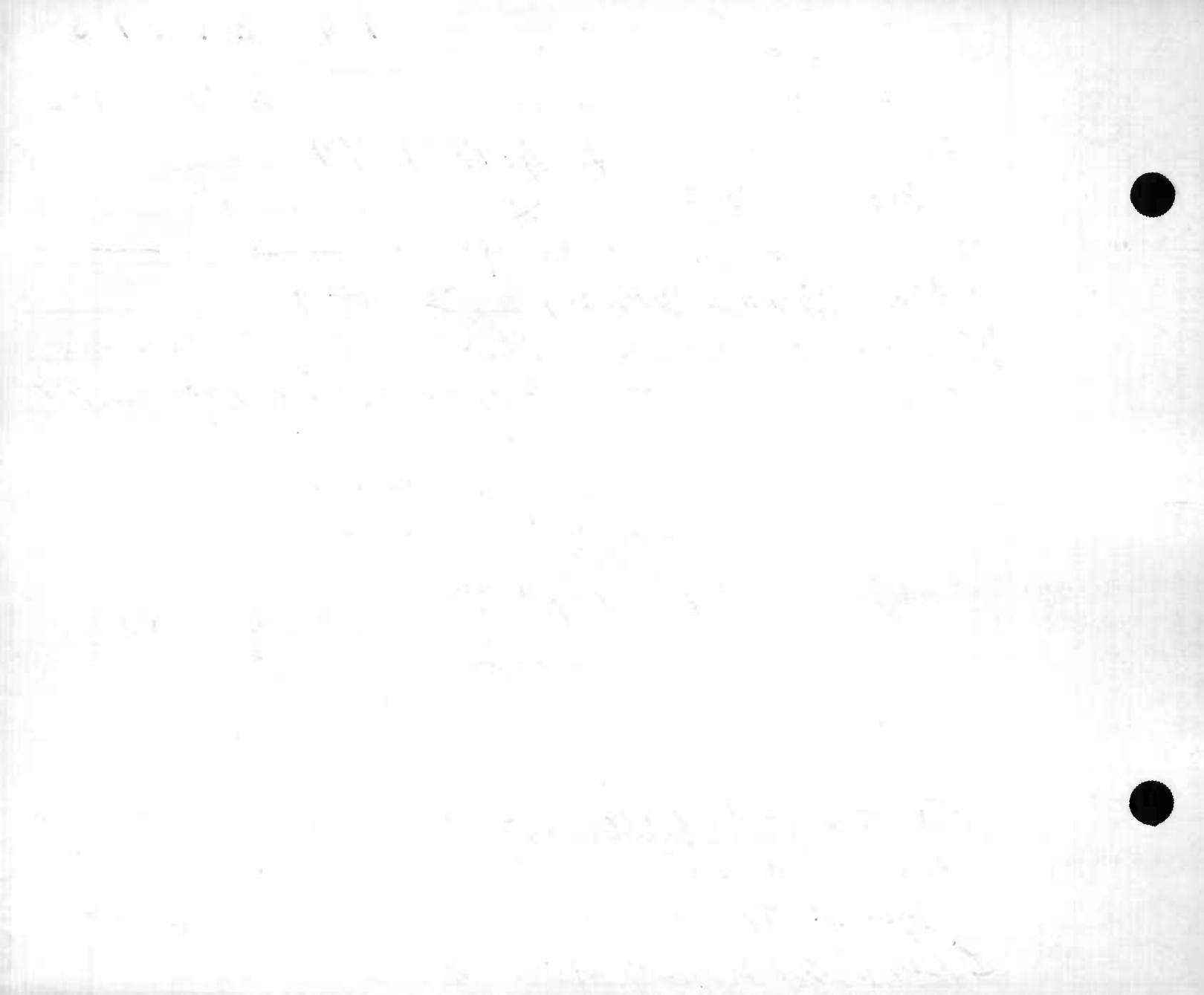
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 9 2 1 0 7 3 | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|--|---|--|----------------------|--|
| 1. FOR STATE REGISTRAR | | | 2. DATE OF DEATH 08 18 79 | | | | | | | 3. HOUR 1:45 A.M. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Melissa M Furbush</i> | | | 4. FIRST MIDDLE LAST | | | 5. DATE OF BIRTH 4-18-79 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 90 | | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | | |
| 8. SEX Female | | | 9. RACE White | | | 10. BIRTHPLACE STATE OR FOREIGN COUNTRY Md | | | 11. CITIZEN OF WHAT COUNTRY? U.S. | | | 12. BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | | |
| 13. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | 14. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Wicomico Nursing Home | | | 16. USUAL OCCUPATION | | | 17. KIND OF BUSINESS OR INDUSTRY | | | |
| 18. STATE MD | | | 19. COUNTY Wicomico | | | 20. CITY OR TOWN Wetipawin | | | 21. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 22. STREET ADDRESS 871 | | | |
| 23. FATHER'S NAME William H. Dann | | | 24. MOTHER'S MAIDEN NAME Max C. Coulbourne | | | 25. WAS DECEASED EVER IN U.S. ARMED FORCES? No | | | 26. SOCIAL SECURITY NO. - | | | 27. INFORMANT Esther Robertson, Tyaskin, MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 10, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vasular Accident</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <i>Generalized arteriosclerosis</i> (c) <i>Decubitus ulcers</i> | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Faint air stay typhemic</i> | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED 08-20-79 | | | | | |
| 22b. SIGNATURE <i>A.C. Mitchell</i> DEGREE | | | | | | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>A.C. Mitchell</i> | | | | | | | | | | 22e. ADDRESS <i>Po Box 2378 Salisbury, MD 21801</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | 23b. DATE 8/21/79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL <i>Wetipawin Cem.</i> | | | 23d. LOCATION CITY OR TOWN <i>Wetipawin, MD</i> | | | 23e. COUNTY <i>Wicomico</i> | | 23f. STATE <i>MD</i> | |
| 24. FUNERAL DIRECTOR <i>C. Morrissey, Bivalve, MD</i> | | | 25a. ADDRESS | | | 25b. DATE REC'D. BY REGISTRAR AUG 24 1979 | | | 25c. REGISTRAR'S SIGNATURE <i>John McElroy</i> | | | | | | |

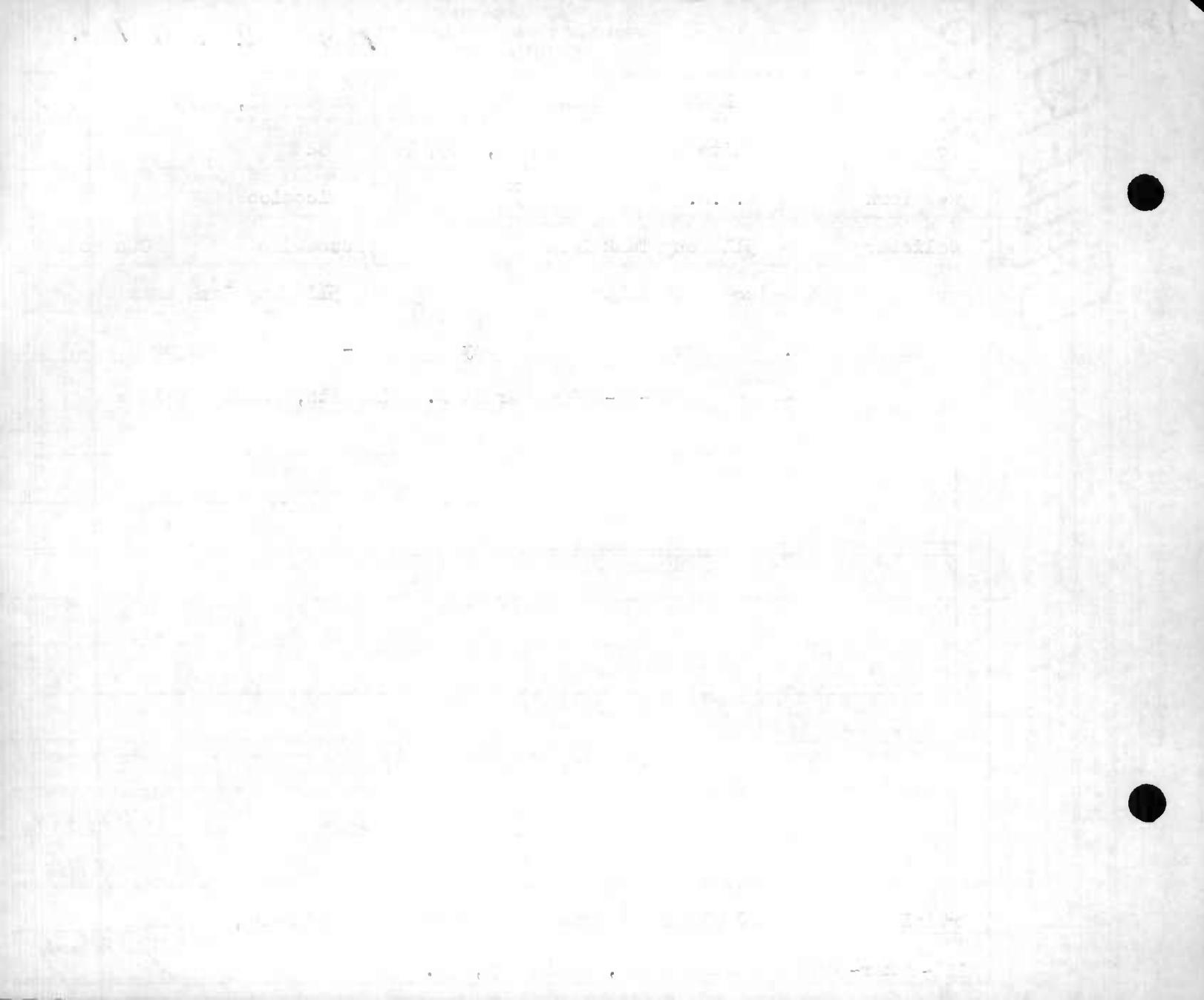


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be used within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. | | | | | | | |
|--|--|--|---|------------------------|---|---|--|-------------|---|--|--|--|--------------------------------|--|---------------------------------------|--|--|--|--|
| 1 - FOR STATE REGISTRAR | | | 2 - DATE OF DEATH MONTH DAY YEAR | | | | | | | | | 2b HOUR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST OLIVE | MIDDLE LANCE | LAST GALBRAITH | 2a DATE OF DEATH MONTH DAY YEAR | | | | | | | | | 2b HOUR | | | | |
| 3. SEX Female | | | 4. RACE White | | | 5. DATE OF BIRTH MONTH DAY YEAR March 6, 1897 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | | 10. CITY OR TOWN OF DEATH Salisbury | | | | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 511 Tony Tank Lane | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | | 13a. STATE Maryland | | | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | | | |
| 14. FATHER'S NAME FIRST Joseph | | | MIDDLE L. | LAST Lance | 15. MOTHER'S MAIDEN NAME FIRST May | | | MIDDLE - | LAST Heger | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | 16b. SOCIAL SECURITY NO. 216-46-8693 | | | 17. INFORMANT Grant N. Galbraith, Same as 13 e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Coronary Artery Disease/Myocardial Infarction | | | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min | | | 20a. DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease/Myocardial Infarction | | | 20b. DUE TO, OR AS A CONSEQUENCE OF (c) Anemia | | | 21. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | |
| 21a. DATE OF OPERATION | | | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 21c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | |
| 21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21f. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21g. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21h. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21i. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 1118 | | | 21j. LOCATION STREET 215 Ohio | | | 21k. CITY OR TOWN Salisbury | | | 21l. COUNTY Wicomico | | 21m. STATE Maryland | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/18 , 19 79 , to 8/11 , 19 79 , that (I) (we) last saw the deceased alive on 11/18 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | | | 22b. DATE SIGNED 8/14/1979 | | | | | | | |
| 22c. SIGNATURE J. D. Rafferty | | | 22d. DEGREE | | | 22e. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | | | | |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT) J. D. Rafferty | | | 22g. ADDRESS 215 Ohio Salisbury, MD | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 8/14/1979 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery | | | 23d. LOCATION CITY OR TOWN Salisbury, Maryland | | | 23e. COUNTY Wicomico | | 23f. STATE Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME Hill-Baker-Bounds Funeral Home, Salisbury, Md. | | | 25a. ADDRESS 1118 | | | 25b. DATE REG'D BY REGISTRAR AUG 17 1979 | | | 25c. REGISTRAR'S SIGNATURE R. J. Brady | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be dated for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 9 21075 | | | | | | |
|--|--|--|---|--|---|--|----------|---|---|---|--|---|---|--------|--|--|--------------------|--------------|
| 1. FOR STATE REGISTRAR | | | (GARRISON) | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | | MIDDLE | | Garrison | | | August 20, 1979 | | 2:25 A.M. | | | | | | |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | |
| Male | | | White | | Oct. 23, 1911 | | | 67 | | | MONTHS DAYS | | HOURS MIN | | | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | | | | | |
| Maryland | | | U.S.A. | | | | | Wicomico | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Salisbury | | | Peninsula General Hospital | | | | | | | | Captain Fishing | | | | | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Somerset | | 13c. CITY OR TOWN Crisfield | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Hall Highway | | | | | | | | |
| 14. FATHER'S NAME FIRST Guy | | | MIDDLE W. | | LAST Garrison | | | 15. MOTHER'S MAIDEN NAME FIRST May | | LAST Nelson | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 16c. INFORMANT | | | 17. ADDRESS | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| no | | | none | | 216-01-6202 | | | Mrs. Ida Mae Johns | | Same as 13 a,b,c,d,e | | | | 6 mos. | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Car cancer lung</i> | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last</i> | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION <i>8-20-79</i> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ca lung</i> | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8-16</i> , 19 <i>79</i> to <i>8-20</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>8-20</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We did) (I did not) view the body after death. | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>E. KENT PARNEY</i> | | | 22c. DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d. DATE SIGNED <i>8-20-79</i> | | | | | | | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>E. KENT PARNEY</i> | | | 22f. ADDRESS <i>233 FLORIDA AVE SALISBURY MD. 21801</i> | | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE <i>8/22/79</i> | | | 23c. NAME OF CEMETERY OR CREMATORIAL Sunnyridge Cemetery | | | 23d. LOCATION CITY OR TOWN Crisfield | | COUNTY Somerset | STATE Md. |
| 24. FUNERAL DIRECTOR NAME Bradshaw & Sons | | | ADDRESS Crisfield, Md. 21817 | | | 25b. DATE REC'D. BY REGISTRAR <i>AUG 24 1979</i> | | | 25c. REGISTRAR'S SIGNATURE <i>Linda Bradbury</i> | | | | | | | | | |
| DHMH - 16 60M 1/75 (VRA 15 (4)) | | | | | | | | | | | | | | | | | | |

22-10-09 11:15 a.m.

Location: Laramie River

Water level: 1000 ft

Water temp: 50° F

Water clarity: 10 ft

Wind speed: 0 mph

Wind direction: NNE

Cloud cover: 0%

Sun angle: 0°

Humidity: 0%

Barometric pressure: 0

Wind gusts: 0 mph

Wind gust direction: NNE

Wind gust angle: 0°

Wind gust humidity: 0%

Wind gust barometric pressure: 0

Wind gust wind direction: NNE

Wind gust sun angle: 0°

Wind gust cloud cover: 0%

Wind gust water temperature: 50° F

Wind gust water clarity: 10 ft

Wind gust water level: 1000 ft

Wind gust water pressure: 0

Wind gust water density: 0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please notify me.

rejoined by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

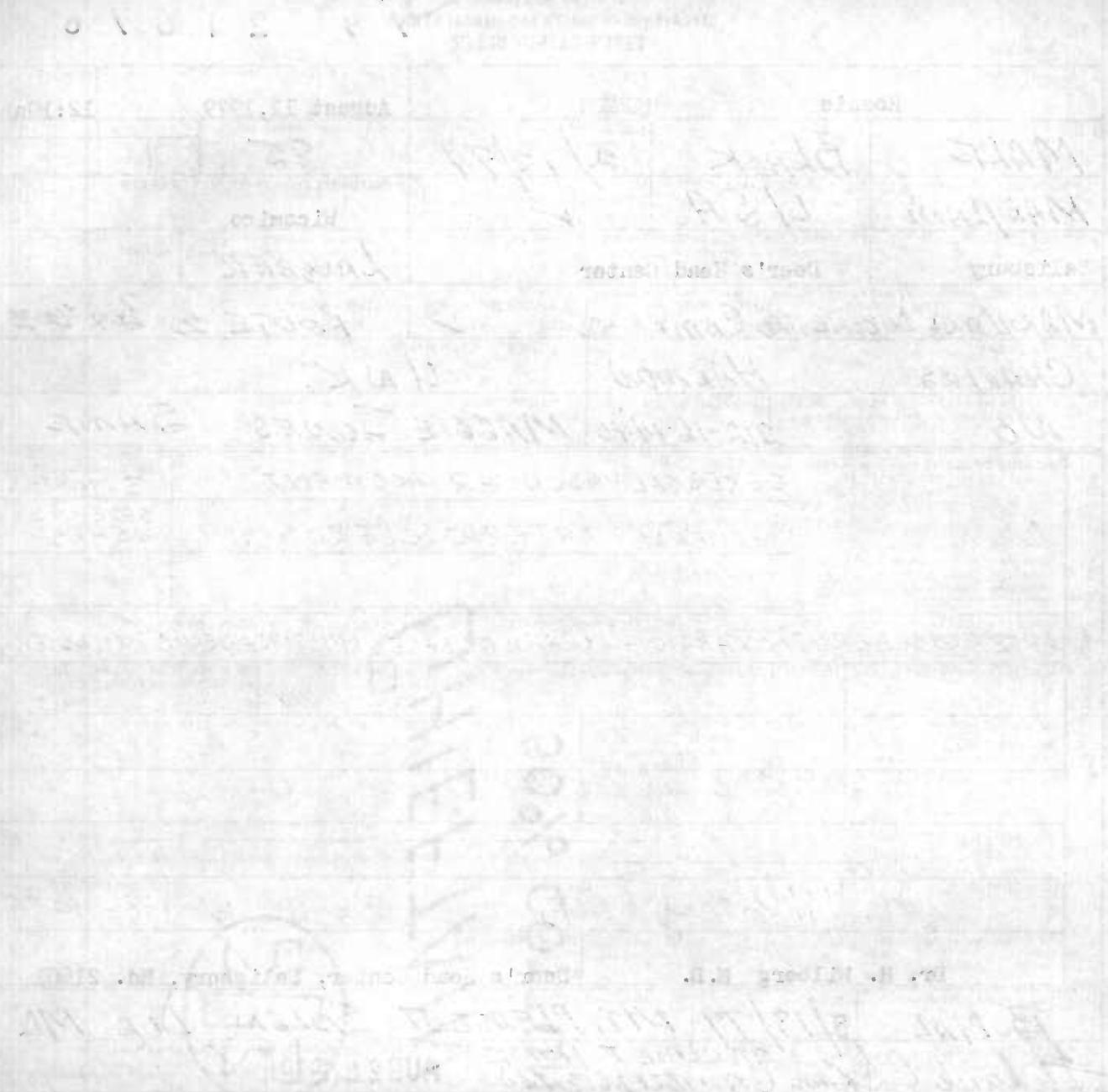
MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 9 21076

| | | | | | | | | | |
|---|--|--|--|---|--|---|---|---------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST Rossie | MIDDLE HARMON | LAST | 2a. DATE OF DEATH August 11, 1979 | MONTH DAY YEAR | 2b. HOUR 12:10 a.m. | |
| 3. SEX MALE | | | 4. RACE Black | 5. DATE OF BIRTH MONTH 2 DAY 13 YEAR 1974 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE COUNTRY Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER | | | |
| 13a. STATE Maryland | | | 13b. COUNTY St. Mary's | | 13c. CITY OR TOWN Cambridge | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS ROUTE 2 Box 303 | | |
| 14. FATHER'S NAME FIRST CHARLES | | | MIDDLE | LAST HARMON | 15. MOTHER'S MAIDEN NAME FIRST UNK. | | | LAST | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 212-16-1440 | | 17. INFORMANT MAGGIE JONES | ADDRESS SAME | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | CEREBRAL VASCULAR ACCIDENT | | | | | | |
| 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | DUE TO, OR AS A CONSEQUENCE OF (b) GENERAL ARTERIOSCLEROSIS | | | | | | |
| | | | DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE, MULTIPLE DECUBITUS ULCERS | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET | | CITY OR TOWN | COUNTY | STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE H. Wilberg MD | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8/18/79 | 23c. NAME OF CEMETERY OR CREMATORIAL MT. PLEASANT | | 23d. LOCATION CITY OR TOWN St. Mary's | 23e. COUNTY Dor. MD | 22f. DATE SIGNED 8-11-79 | | |
| 24. FUNERAL DIRECTOR NAME Judith C. F. Home | | 25a. DATE REC'D. BY REGISTRAR AUG 22 1979 | | 25b. REGISTRAR'S SIGNATURE Patricia McCreary | | | | | |

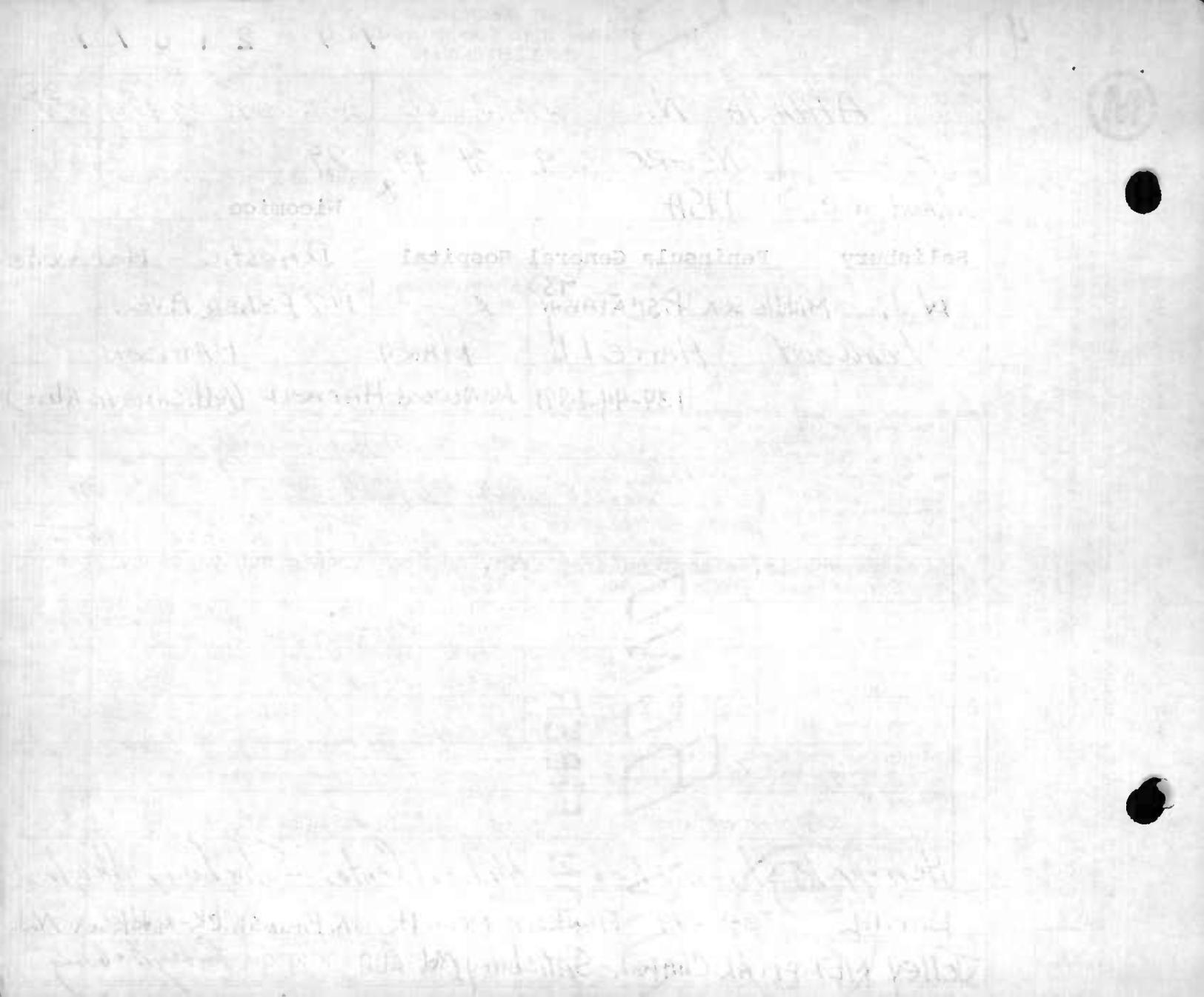


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. DECEASED NAME (TYPE OR PRINT) | | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN |
|--|-----------------------------|-----------------------------------|----|--|--|------|-------------------|--|------|------|---|
| ATHALIA N. HARRELL | | | | | | | AUGUST | 2 1 0 7 7 | 8 20 | YRS | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH MONTH DAY YEAR | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | 7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | | |
| F | NEGRO | 9 | 34 | 49 | 39 | | | | | | |
| 7a. BIRTHPLACE COUNTRY | STATE OR FOREIGN COUNTRY | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| HIGHLAND, N.C. | USA | | | | | | | Wicomico | | | |
| 10 CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | |
| Salisbury | | | | Peninsula General Hospital | | | | Domestic Housewife | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | TS | | | | | 147 Fisher Ave. | | | |
| 14 FATHER'S NAME LAST MIDDLE LAST | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| Lewwood | | | | MARY | | | | Harrison | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | |
| (If Yes, Give War or Dates) | | | | 139-44-6891 | | | | Lewwood Harrell (Add. same as above) | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and c. PART I. DEATH WAS CAUSED BY | | | | IMMEDIATE CAUSE (a) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 5308 | | | | Upper gastro intestinal hemolytic | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | DUE TO, OR AS A CONSEQUENCE OF (b) | | | | 5 wks | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF (c) | | | | Death resulting postile biliary | | | |
| | | | | | | | | Biliary obstruction following Clasper's factor/obstruction | | | |
| PART II. OTHER PREDISPOSING CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | Causes of death due to biliary colic bypass | | | | result of fracture of the duodenum | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED OR DENTAL OPPORTUNITY | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| 6/28/79 | | | | Fracture of the | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | | | Injury due to falls products | | | | fall 16 yrs ago | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | | | 6-17 1979 | | | | to 8-1 1979 | | | |
| saw the deceased alive on 8/1 1979 | | | | | | | | | | | |
| above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| Henry K Shoemaker | | | | Md | | | | 8/1/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | |
| Henry K Shoemaker | | | | Medical Center Salisbury Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | |
| Burial | | | | 8-8-79 | | | | FRANKLIN Mem. bk. | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | |
| Tolley Memorial Chapel - Salisbury MD | | | | | | | | AUG 11 1979 | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| | | | | | | | | Henry Shoemaker | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 21078 | | |
|---|--|--|--|--|--|--|--|--|--|----------------|--|--|
| 1 - FOR STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR Aug. 12, 1979 | | | | | | | 2b. HOUR M | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE DOLLIE LAVENIA | | | LAST HASTINGS | | | | | | |
| 3. SEX Female | | | 4. RACE White | | | 5. DATE OF BIRTH MONTH DAY YEAR March 25, 1893 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 yrs | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 403 Pinehurst Ave. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY none | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Wicomico | | | 13c. CITY OR TOWN Salisbury | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST Merrell | | | MIDDLE Morris | | | 15. MOTHER'S MAIDEN NAME FIRST Mary | | | MIDDLE LAST (unknown) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 220-32-0792 | | | 17. INFORMANT (husband) ADDRESS Mr. W. Gorman Hastings same as 13 | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebrovascular occlusion</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH min. 4349 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>cerebrovascular arteriosclerosis</u> yrs (c) <u>generalized arteriosclerosis</u> yrs | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 19 77</u> to <u>Aug. 19 79</u> , that (I) (we) last saw the deceased alive on <u>July 19 79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <u>John T. Bulkeley M.D.</u> | | | 22c. DEGREE M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d. DATE SIGNED 8-14-79 | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) John T. Bulkeley, M.D. | | | 22f. ADDRESS Salisbury, Maryland | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 8/15/79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park, Salisburys, Wic., Md. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, | | | ADDRESS Salisburys, Md. | | | 25a. DATE REC'D. BY REGISTRAR AUG 21 1979 | | | 25b. REGISTRAR'S SIGNATURE <u>Holloway McBrady</u> | | | |

10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|---|--|-------|------------------|----------|
| FOR STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 9 | 2 | 1 | 0 | 7 | 9 |
| | | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| ACHSAH WAXIE | | D. | | HUDSON | | AUGUST 15 1979 | | 2 | 15 | M | 245 |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| FEMALE | | WHITE | | JULY 8 1901 | | 78 | | MONTHS | YEARS | MONTHS | HOURS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | MD. | | | |
| DELAWARE | | USA. | | | | Wicomico | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NAME AND ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Salisbury | | Peninsula General Hospital | | | | HOUSEWIFE | | OWN HOME | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | R.F.D. | |
| MARYLAND | | WORCESTER | | SELBYVILLE | | | | | | | |
| 14. FATHER'S NAME | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | ADDRESS | | R.F.D. | |
| FRANK | | | | DAISEY | | ANNA | | | | GREEN | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| (IF YES, GIVE WAR OR DATES) | | 221-50-2440 | | | | ROLLIE HUDSON SELBYVILLE DEL | | 72 hrs | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | cerebral thrombosis | | | | | | | | | |
| 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | b) cerebral arteriosclerosis | | | | | | | | 4 yrs | |
| | | c) generalized arteriosclerosis | | | | | | | | 4 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a diabetes mellitus, probable subdaphragmatic abscess | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | P.M. | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 19 68 to Aug 15 1979, that (I) (we) last saw the deceased alive on Aug 15 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN | | MEDICAL DIRECTOR | | STAFF PHYSICIAN | | 22c. DATE SIGNED | |
| John G. Belsley M.D. | | | | | | | | | | 8-16-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (COP) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN | | 23d. LOCATION CITY OR TOWN | | 23e. COUNTY | | 23f. STATE | |
| BORAL | | 8/18/79 | | BETHEL MARINERS OCEAN VIEW DEL | | CITY OR TOWN | | COUNTY | | STATE | |
| 24. FUNERAL DIRECTOR (NAME) Peter Whaley Selbyville Del. | | 25. DEATHBEDS 26. RECREATION 27. DEPARTURE TIME | | | | | | | | | |
| | | AUG 23 1979 | | | | | | | | | |

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Indians forced to move inland.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 19 21080 | |
|--|--|--|---|--------------------|-------|---|-----------|---------------------------------|--|--------|-----------------|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | |
| <i>ROLLIE P. HUDSON</i> | | | | | | <i>AUGUST 20, 1979</i> | | | | | | <i>10 AM</i> | |
| 3. SEX | | | 4 RACE | S. DATE OF BIRTH | MONTH | DAY | YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | IF UNDER 24 HRS | |
| <i>MALE</i> | | | <i>WHITE</i> | <i>FEB 19 1901</i> | | | <i>78</i> | | | MONTHS | DAYS | HOURS | MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | |
| <i>MARYLAND</i> | | | <i>U.S.A.</i> | | | | | | <i>Wicomico</i> | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| <i>Salisbury</i> | | | <i>Peninsula General Hospital</i> | | | <i>PET PAINTER</i> | | | <i>HOUSE</i> | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS | | | | |
| <i>MARYLAND</i> | | | <i>WORCESTER</i> | | | | | | <i>SEIBYVILLE DEL R.F.D.</i> | | | | |
| 14. FATHER'S NAME | | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | | FIRST | MIDDLE | LAST | | |
| <i>JAMES EDW. HUDSON</i> | | | | | | <i>MARY ISABELLE GRAY</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | |
| (If Yes, give war or dates) | | | <i>222-14-2238</i> | | | <i>PHYLLIS MEYER SALISBURY, MD.</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cardiac failure (Cyst. Autol. Day 4409</i> | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>other diseases</i> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Dealing with stress</i> <i>neglect of self</i> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY | STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/16/79</i> to <i>8/20/79</i> , that (I) (we) last saw the deceased alive on <i>8/20/79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | 22c. DATE SIGNED |
| 22b. SIGNATURE <i>J. Green</i> | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | <i>8/20/79</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOHN G. GREEN</i> | | | 22e. ADDRESS <i>215 OHIO AVE. SALISBURY, MD</i> | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL <i>BURIAL</i> | | | 23b. DATE <i>8-23-79</i> | | | 23c. NAME OF CEMETERY OR CREMATORIAL <i>BETHEL MARINER</i> | | | 23d. LOCATION CITY OR TOWN <i>OCEANVIEW SUSSEX DEL</i> | | | | |
| 24. FUNERAL DIRECTOR <i>Terry Whaley Salisb. Del.</i> | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR <i>AUG 27 1979</i> | | | 25b. REGISTRAR'S SIGNATURE <i>John G. Green</i> | |

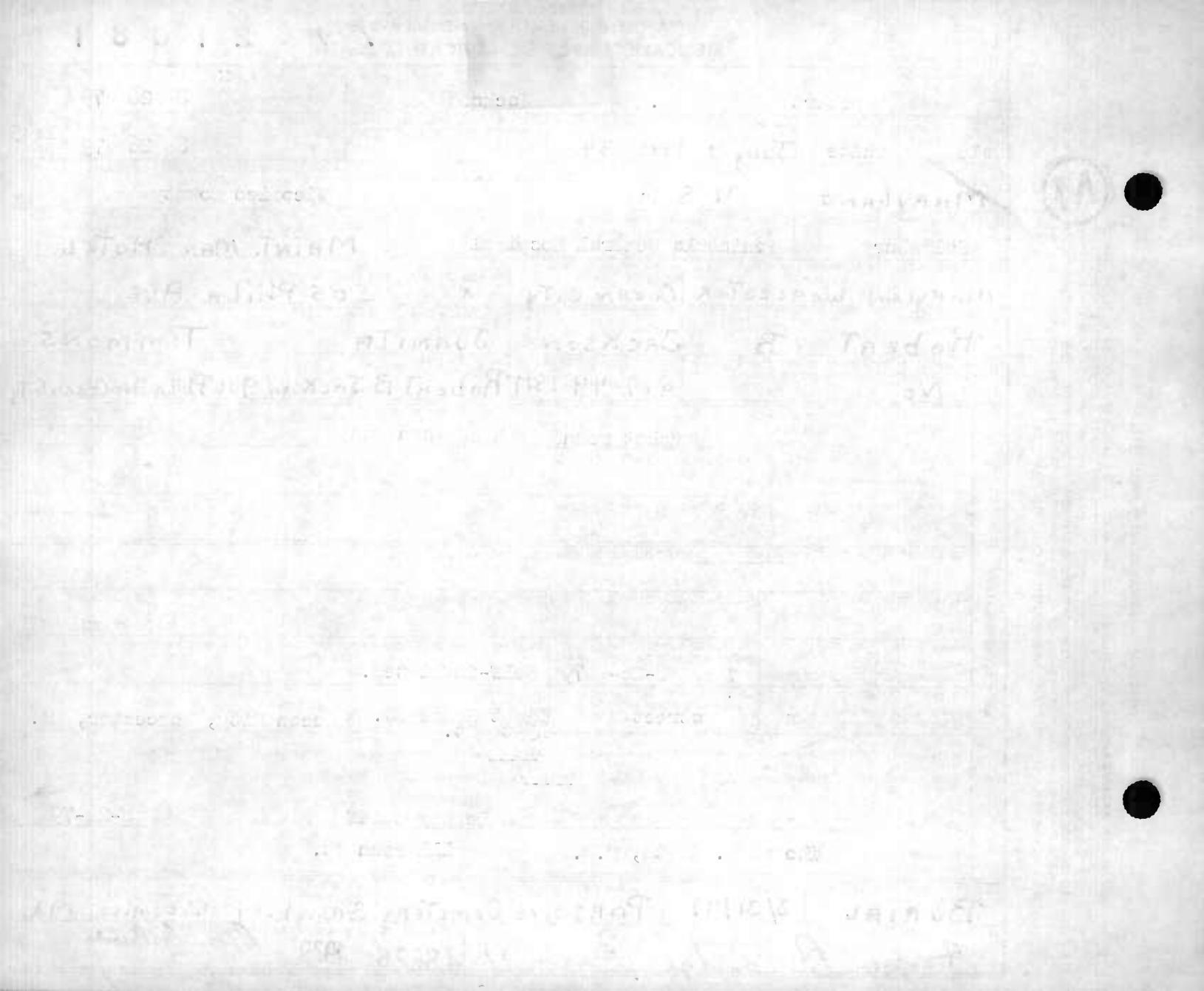
NICOTYCO

BENTONIA CENTER MORTGAGE

COLLEGE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR; PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3 RETAIN PAGE 4 FOR FUNERAL DIRECTOR; PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, Cremation, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 21081 | | | |
|---|--|--|--|---|--------|---|--|----------------------------------|--|----------------------------------|---|--|----------|---|--|
| 1- FOR STATE REGISTRAR | | FIRST | | | MIDDLE | | | LAST | | | 2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR | | 2b. HOUR | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | Robert | | | L. | | | Jackson | | | 8 26 1979 | | M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YR. MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR MONTH DAY YEAR | |
| male | | white | | July 4 1945 | | 34 yrs. | | | | | | 8 26 1979 | | 1:45 p.m. | |
| 10a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 11b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland | | U.S.A. | | | | | | | | | | | | Wicomico County | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Salisbury | | Peninsula General Hospital | | | | | | | | | | MAINT. MAN | | HOTEL | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | | | | |
| Maryland | | Worcester | | Ocean City | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 505 Phila. Ave | | | | | | | |
| 14. FATHER'S NAME FIRST | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME FIRST | | MIDDLE | | LAST | | | | | |
| ROBERT | | B. | | JACKSON | | JUANITA | | | | TIMMONS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | |
| No | | 217-441817 | | ROBERT B. JACKSON | | 906 Phila. Ave Ocean City | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head (handgun)</u> DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 8-26-1979 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self-inflicted. | | 20. AUTOPSY? | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street | | 21f. LOCATION STREET 39th St. | | CITY OR TOWN Ocean City, Worcester, Md. | | COUNTY | | STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Thomas D. Smith</i> | | | | TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | Thomas D. Smith, M.D. | | ADDRESS 111 Penn St. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (FY) | | 23b. DATE 8/31/79 | | 23c. NAME OF CEMETERY OR CREMATORIUM PARSONS CEMETERY | | 23d. LOCATION CITY OR TOWN Salisbury | | 23e. COUNTY Wicomico | | STATE Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS Anna R. Burridge Birth M | | 25a. DATE REC'D. BY REGISTRAR SEP 6 1979 | | 25b. REGISTRAR'S SIGNATURE <i>Patsy McCloskey</i> | | | | | | | | | |
| BP | | | | | | | | | | | | | | | |
| DHMH - 17 IVR A15 ME (5) 15M 7/76 | | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retumed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the State Dept. of Health and Mental Hygiene prior to burial/cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 79 21082 | |
|--|--|--|---|--|--|---|--|--|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR | | | 2a DATE OF DEATH MONTH DAY YEAR | | | | | | | | | 2b HOURS | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 5 DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 1c SEX F | | | 4 RACE Black | | | 11 20 1903 | | | 75 | | | IF UNDER 24 HRS YRS | |
| 7a BIRTHPLACE STATE OR FOREIGN COUNTRY Md. | | | 7b CITIZEN OF WHAT COUNTRY? U.S. | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | | | |
| 10 CITY OR TOWN OF DEATH Salisbury | | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER | | | 12b. KIND OF BUSINESS OR INDUSTRY SeaFood | | | | |
| 13a STATE Md. 13b COUNTY Som. 13c CITY OR TOWN Crisfield | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e STREET ADDRESS 314 Chesapeake Ave. | | | | | | | |
| 14 FATHER'S NAME FIRST John MIDDLE LAST GREEN | | | 15 MOTHER'S MAIDEN NAME FIRST TENNIE MIDDLE L. LAST Joyner | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No 16b SOCIAL SECURITY NO. 213-10-8013 17 INFORMANT ADDRESS LOUISE A. Lake-Crisfield, Md. | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410- Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <i>hypertension</i> (c) <i>cardiovascular disease</i> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>some</i> <i>2 wks</i> <i>15 yrs</i> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/27, 1979, to 8/15, 1979, that (II) (we) last saw the deceased alive on 8/14, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | 22c. DATE SIGNED | |
| 22b. SIGNATURE <i>J.L. Ratteau</i> | | | 22e. DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J.L. Ratteau</i> | | | 22g. ADDRESS | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 8/18/79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Asbury | | | 23d. LOCATION CITY OR TOWN Lawsonia | | | STATE Md. | |
| 24. FUNERAL DIRECTOR NAME <i>Halley Elwood Campbell</i> | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR AUG 17 1979 | | | 25b. REGISTRAR'S SIGNATURE <i>John J. Murphy</i> | | | | |

CELESTE

PERIODIC CHANGES IN BODY

OBSTACLES

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7921083

| | | | | | | | | | | | |
|--|--|--|--|--|---|------------------|-------------------------------------|---|------------------|---|---------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | FIRST | MIDDLE | LAST | 2a DATE OF DEATH | MONTH | DAY | YEAR | 2b HOUR |
| Mary S. JENNINGS | | | | | | | AUGUST | 9, 1979 | 12 ¹⁵ | PM | |
| 3. SEX | | 4 RACE | | 5 DATE OF BIRTH | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | |
| female | | white | | MONTH May DAY 12, 1911 YEAR | | | 68 YRS | | | # UNDER 24 HRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | 10 CITY OR TOWN OF DEATH | |
| Maryland | | USA | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | Wicomico | | | Salisbury | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | | |
| Peninsula General Hospital | | | | | | | | | | | |
| 13a STATE | | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS | |
| Virginia | | | | Accomac | | Wallops | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | H-15 | |
| 14 FATHER'S NAME | | | | 15 MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST William Henry Schoolfield | | | | FIRST Amy S. Blaine | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b SOCIAL SECURITY NO. | | | 17 INFORMANT | | | 18a APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| no | | | | 113-18-4142 | | | Alice J. Tarr | | | 50 Strayhorn Lane Elkton, Md. 21921 | |
| 18b CAUSE OF DEATH (Enter only one cause per line for (a), (b), and c) PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>cardiorespiratory Arrest</i> 2869 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b), DUE TO, OR AS A CONSEQUENCE OF prob. <i>Intracranial Haemorrhage</i> <i>Anticoagulation</i> | | | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Pulmonary Embolism, metastatic carcinoma - pathologic evidence</i> | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? | | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7.27.1979 to 8.9.1979, that (I) (we) last saw the deceased alive on 8.9.1979, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>D. Saggar</i> | | 22c. DEGREE MD | | | 22d. ADDRESS 547 Riverside Ave. Suite Salisbury | | | 22e. DATE SIGNED 8/9/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>D. Saggar</i> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION CITY OR TOWN | | COUNTY | | STATE |
| Burial | | 8/11/79 | | Salem Meth. Cem. | | | Pocomoke | | Worcester | | Md. |
| 24 FUNERAL DIRECTOR NAME | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Scotts. Melon | | Pocomoke City, Md. | | | AUG 14 1979 | | | <i>Holiday McCreary</i> | | | |

Subject: American General Hospital

Address: 400 1st Street

Telephone: 444-5111

Date:

Time: 10:00 AM
Name: Dr. John C. H. Smith

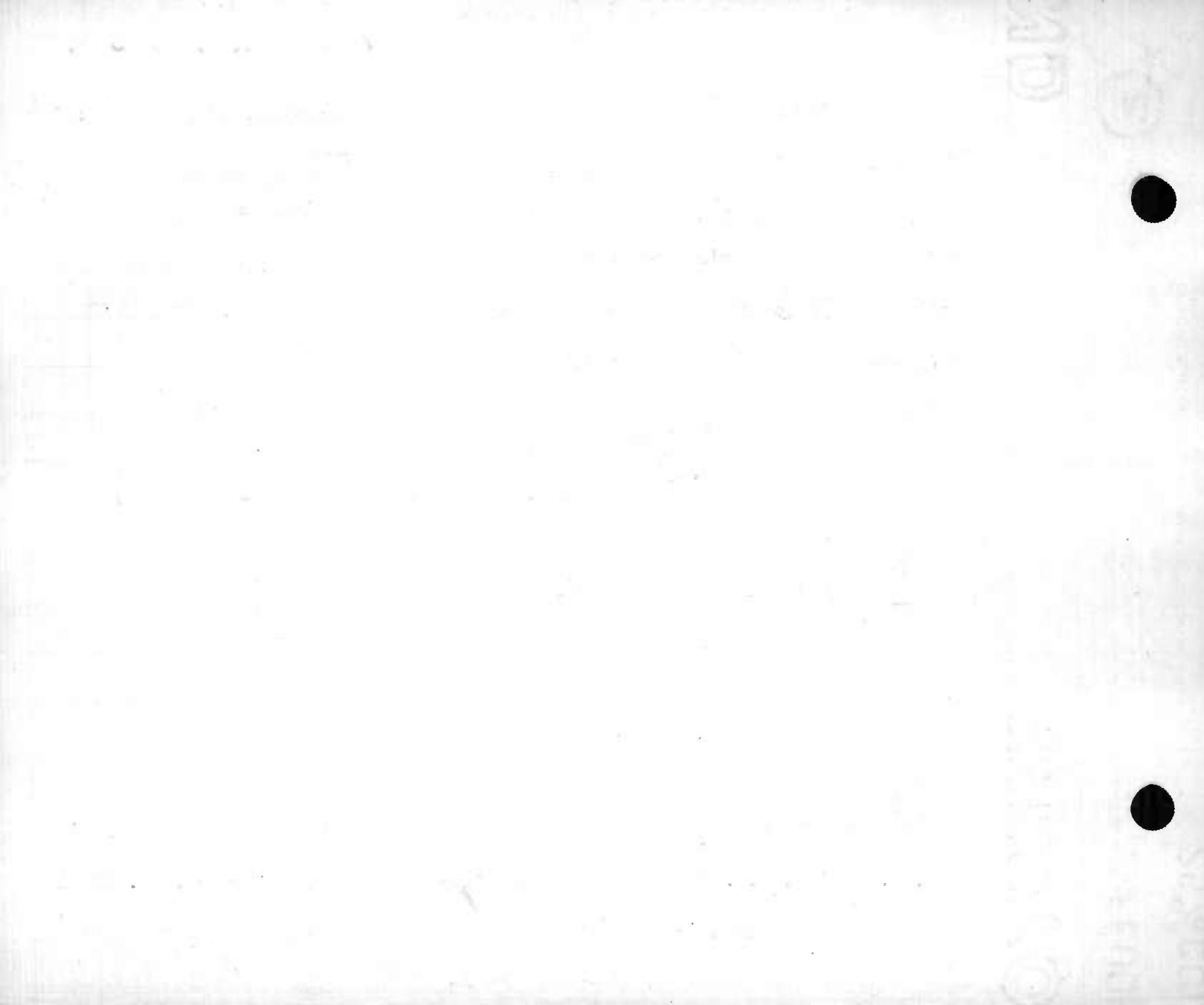
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 9 2 1 0 8 4 | | |
|--|--|--|---|--|--|--|--|---|---|----------------------|--------------------------------|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | | | 2b. HOUR | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE | | | LAST | | August 5, 1979 | | | 7:30 AM | |
| Elsie | | | | | | JOHNSON | | | | | | |
| 3 SEX | | | 4 RACE | | | 5 DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR MONTHS DAYS | |
| Female | | | Negro | | | 12 20 90 | | 88 YRS | | | IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | |
| Md | | | USA | | | | | Baltimore City or County of Death Wicomico | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Salisbury | | | Deer's Head Center | | | Domestic | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS | |
| Md | | | Talbot | | | Fostoria | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | South St | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | |
| Charles | | | Ella Dickerson | | | Z | | 217-30-8251 | | | Freda Jennings | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | 19. DUE TO, OR AS A CONSEQUENCE OF (b) | | | 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | PERipheral Vasc. disease | | | Y | | | | | | |
| 21b. DUE TO, OR AS A CONSEQUENCE OF (c) | | | PERipheral Vasc. disease | | | Y | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pneumonia | | | | | | | | | | | | |
| 20a. DATE OF OPERATION | | | 20b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (I did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d. DATE SIGNED | | | |
| L. V. Maldive, M.D. | | | | | | | | | 8/5/79 | | | |
| 23a. BURIAL, CREMATION, REMOVAL <u>SPECIES</u> | | | 23b. DATE 8/5/79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Paradise | | | 23d. LOCATION CITY OR TOWN Tropicana Inn | | | |
| 24. FUNERAL DIRECTOR NAME George H. Marshall Center | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR AUG 17 1979 | | | 25b. REGISTRAR'S SIGNATURE Larry Helms | | | |
| BP | | | | | | | | | | | | |

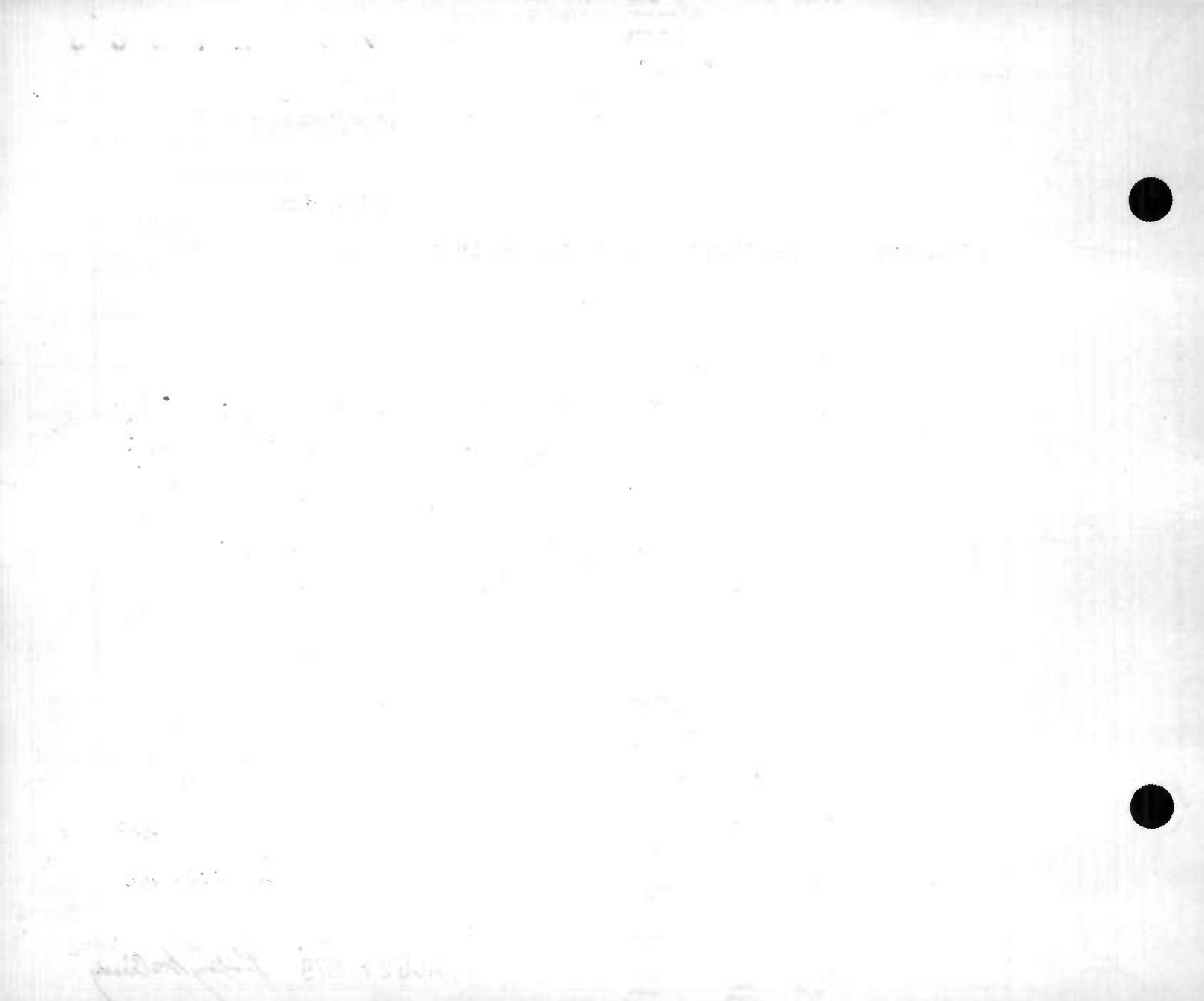


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. | | | | |
|---|--|--|---------------------------------|---|------|---|--|--|-----------------------|-----------------------|--|--|--|--|--|--|
| 1 - STATE REGISTRAR | | | 2a DATE OF DEATH MONTH DAY YEAR | | | | | | | | | 2b HOUR | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a DATE OF DEATH MONTH DAY YEAR | | | 2b HOUR | | | | | | | |
| WILBER BENSON Johnson | | | | | | August 22, 1979 | | | 5:56 P.M. | | | | | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE IN YEARS LAST BIRTHDAY | | | IF UNDER 1 YEAR | | | | | | |
| Male | | White | | March 7, 1911 | | | 68 | | | MONTHS DAYS HOURS MIN | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | YRS. | | | | | | |
| N. Hampton, | | Va. USA | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | Wicomico | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Salisbury | | Peninsula General Hospital | | Welder | | | Construction | | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 14. FATHER'S NAME FIRST MIDDLE LAST | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS | | | | | | | |
| Maryland | | Wicomico | | James Edward Johnson | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 301 E. Carroll Street | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | ADDRESS | | | (wife) | | | | | | |
| No | | 212-16-7403 | | Mrs. Daisie C. Johnson | | | same as 13 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b1, and 1c1.) PART I. DEATH WAS CAUSED BY | | | | | | | | | | | | IMMEDIATE CAUSE (a) <i>Cerebral vascular accident due to</i> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | | | | | | <i>436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i> | | | | |
| | | | | | | | | | | | | <i>(b) Advanced cerebral arteriosclerosis & chronic congestive heart failure with atrial fibrillation.</i> | | | | |
| | | | | | | | | | | | | <i>(c) Chronic obstructive pulmonary disease with chronic respiratory failure</i> | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | | 20b. WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY STATE | | | | | | |
| | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 12, 1979</i> to <i>Aug 22, 1979</i> , that (I) (we) last saw the deceased alive on <i>Aug 12, 1979</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>J. Sard, M.D.</i> | | | | | | | | | | | | DEGREE | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOSEPH Z. BADROS</i> | | | | | | | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | | | | | | | | | | 22e. DATE SIGNED <i>8-23-79</i> | | | | |
| 23b. DATE <i>8/24/79</i> | | 23c. NAME OF CEMETERY OR CREMATORIAL <i>Wicomico Mem. Park</i> | | 23d. LOCATION CITY OR TOWN <i>Salisbury, Wic., Maryland</i> | | | | | | | | | | | | |
| 24 FUNERAL DIRECTOR NAME <i>HOLLOWAY FUNERAL HOME</i> | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR <i>AUG 28 1979</i> | | | | |
| ADDRESS <i>Salisbury, Md.</i> | | | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE <i>Holloway</i> | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 9 21086 | | | |
|--|--|--|--|--|---|--|---|--|--------|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) GARDNER | | | FIRST | | MIDDLE | | LAST | | | August 7, 1979 155 AM | | | |
| 3. SEX male. | | | 4. RACE Negro | | 5. DATE OF BIRTH MONTH 12 DAY 5 YEAR 15 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS | | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN 0 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Fruitland, Md | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | | MD. | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | | |
| 13a. STATE Md | | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Fruitland | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 102 Broadway St. | | | |
| 14. FATHER'S NAME FIRST Robert MIDDLE Fred | | | LAST Jones | | 15. MOTHER'S MAIDEN NAME FIRST Lillian MIDDLE Emmer LAST Menzie | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. 218-01-4326 | | |
| | | | | | | | | 17. INFORMANT MeLverta Thomas | | | ADDRESS SAME AS above | | |
| 18. CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Liver Failure 5728 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b). (c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. 19 P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3 Aug 79 , 19 79 , to 7 Aug 79 , 19 79 , that (I) (we) last saw the deceased alive on 3 Aug 79 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | 22e. DATE SIGNED 7 Aug 79 | |
| 22b. SIGNATURE EJ Colwell | | | 22c. DEGREE | | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Colwell | | | 22e. ADDRESS P.O. Box Salterton MS | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL SPECIFY BURIAL | | | 23b. DATE 8-11-79 | | 23c. NAME OF CEMETERY OR CREMATORIAL MT. Calvary Cemetery Fruitland, Wicomico, Md | | | 23d. LOCATION CITY OR TOWN | | COUNTY | | | |
| 24. FUNERAL DIRECTOR NAME Valley Funeral Home | | | ADDRESS P.O. #2 Jersey Rd Salisbury, Md | | 25a. DATE REC'D. BY REGISTRAR AUG 13 1979 | | | 25b. DIRECTOR'S SIGNATURE John Colwell | | | | | |

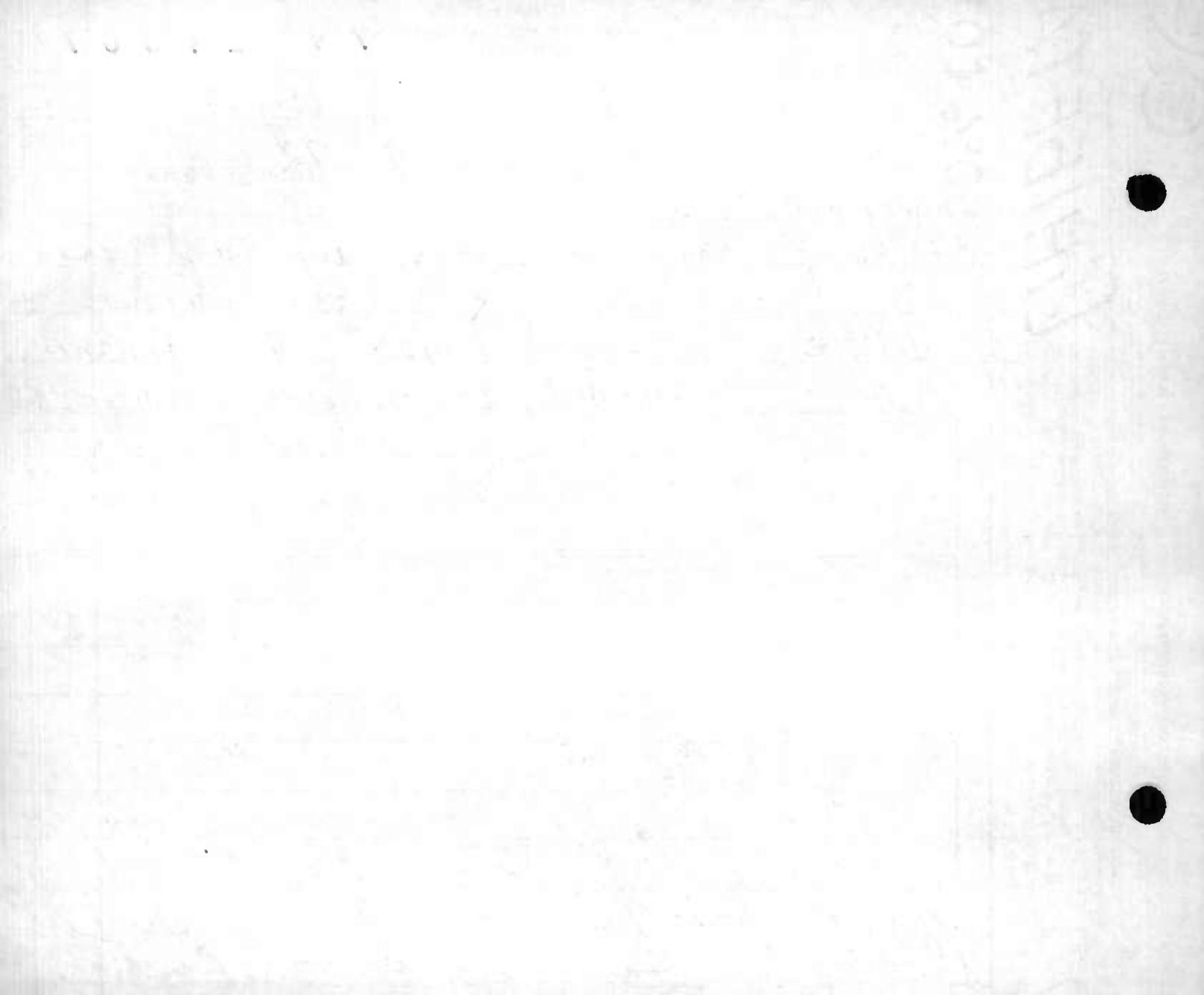
Individually Generalized Variables

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 9 21087 | |
|---|--|--|---|--|--|---|--|--|---|--|--|--|--|
| 1 - FOR STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR Aug 14 79 | | | | | | | | | 2b. HOUR 7a.m. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE SADIE | | | LAST JONES | | | 2a. DATE OF DEATH MONTH DAY / YEAR | | | 2b. HOUR | |
| 3. SEX Female | | | 4. RACE C NEGRO | | | 5. DATE OF BIRTH MONTH DAY YEAR 3 22 07 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 | | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MINUTES | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Waverly Co. | | | 10. USUAL OCCUPATION Campbell Soup York | |
| 10. CITY OR TOWN OF DEATH SALISBURY | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 330 CATHERINE St | | | 12a. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. STATE MD | | | 13b. COUNTY WICOMICO | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 330 CATHERINE St | | | | |
| 14. FATHER'S NAME FIRST Willie MIDDLE | | | 15. MOTHER'S MAIDEN NAME LAST EMILY V PARSONS | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 213-14-1899 | | | 17. INFORMANT WALTER Jones, Baltimore, MD | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (1a) 436- DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension Conditions, if any, which gave rise to immediate cause (1a), stating the underlying cause (1b) (c) DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/25/79 to 7/25/79, that (I) (we) last saw the deceased alive on 7/19/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | | 22c. DATE SIGNED 8/25/79 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | |
| 23a. BURIAL/CREMATION/REMOVAL (SPECIFY) | | | 23b. DATE 8-18-79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL 23d. LOCATION CITY OR TOWN | | | 23e. COUNTY STATE | | | | |
| 24. FUNERAL DIRECTOR NAME West-Fox | | | ADDRESS Salis. Md | | | 25a. DATE REC'D. BY REGISTRAR AUG 17 1979 | | | 25b. REGISTRAR'S SIGNATURE Peter Greene | | | | |

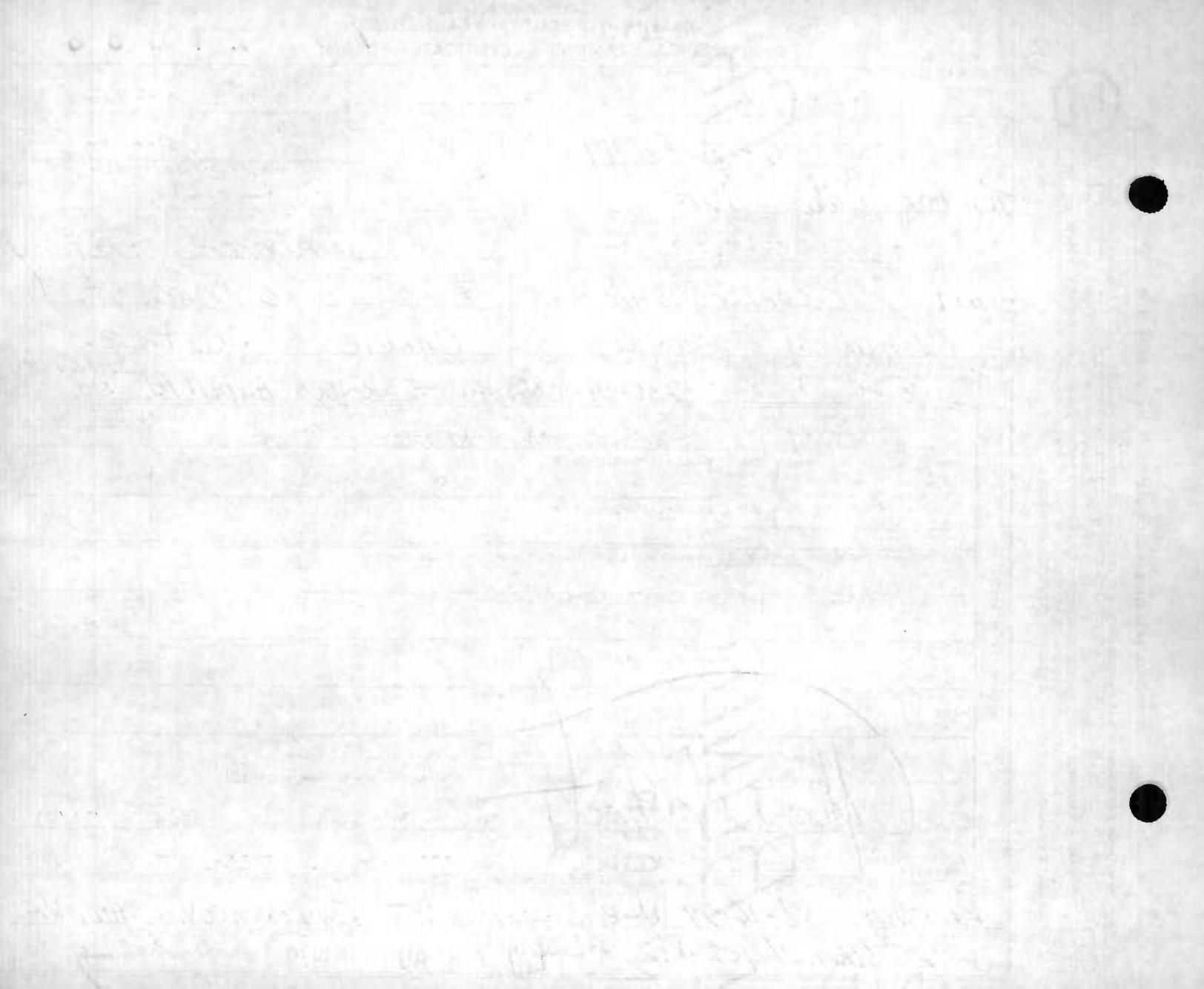




STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 21088

| | | | | | | | | | | | |
|--|---------|--|--|---|---|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | LAST | MIDDLE | LAST | 2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 8 11 1979 M | | | | 2b. HOUR MONTH DAY YEAR 2d HOUR 2:50P M | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | Randolph | | Joynes | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | 7. IF UNDER 1 YR. MONTHS DAYS | 8. IF UNDER 24 HRS. HOURS MIN | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 13 1979 | | | | 2d. HOUR MONTH DAY YEAR 2:50P M | |
| Male | Black | 6 - 8 - 30 | 49 | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wiocomico County, MD. | | | | | |
| 7a. BIRTHPLACE (STATE OR COUNTRY) Temperanceville, VA. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 510 W. Main Street | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Factory | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 510 Main St. | | | |
| 14. FATHER'S NAME Chauncy | | 15. MOTHER'S MAIDEN NAME Joynes | | 16. SOCIAL SECURITY NO. 230-34-7082 | | 17. INFORMANT JAMES Joynes | | 18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | 16b. ADDRESS Airport Rd. Md. | | 16c. PART I DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease | | | | | | | |
| 16d. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LOST. 4292 | | 16e. IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF | | 16f. (b) DUE TO, OR AS A CONSEQUENCE OF | | 16g. (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY AT HOME, STREET, FACTORY, FARM, ETC. | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. ACTUAL SIGNATURE | | 22b. I CERTIFY THAT I TOOK CHARGE OF THE REMAINS DESCRIBED ABOVE, HELD ON DEATH RESULTED FROM: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 22c. TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER | | DATE SIGNED 8/14/79 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | Thomas D. Smith, M.D. | | ADDRESS 111 Penn St. Balto., MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8-16-79 | | 23c. NAME OF CEMETERY OR CREMATORIAL JESUS ALEN BAPTIST | | 23d. LOCATION CITY OR TOWN Temperanceville-ACC. VA. | | 25a. DATE REC'D. BY REGISTRAR AUG 20 1979 | | 25b. REGISTRAR'S SIGNATURE Anthony McBrady | |
| 24. FUNERAL DIRECTOR NAME JOLLEY MEM. CHAPEL - RT 2, SALISBURY MD. | | | | | | | | | | | |
| BP | | | | | | | | | | | |
| DHMH - 17 (VR A15 ME (5)) 15M 7/76 | | | | | | | | | | | |



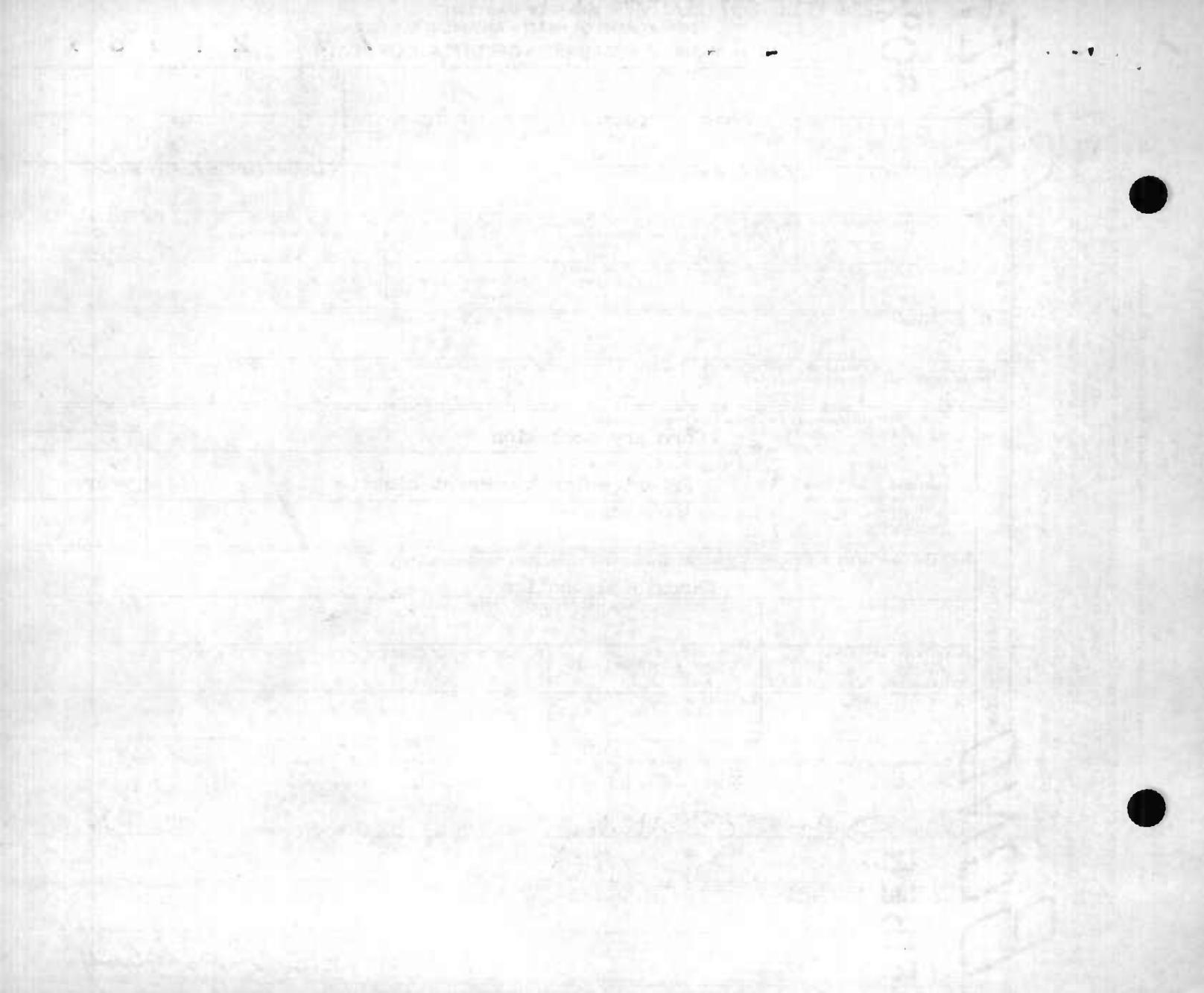
ITEMS #18A-22A FILM G537 11/16/79 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 21089

| | | | | | | | | | | | |
|--|--------|--|------------------------------------|---|--------------------------|---|--|--------------------------------------|----------------------------|---|--------------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | | 2a. DATE KNOWN OF DEATH ESTI- MATED | MONTH | DAY | YEAR | 2b. HOUR |
| | | | SAMUEL | BOLTON | KELLEY | | | | | | 19 M |
| 3. SEX | 4 RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | MONTH | DAY | YEAR | 2d. HOUR |
| Male | White | MONTH DAY | YEAR | MONTHS | DAYS | HOURS | MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED WIDOWED | | NEVER MARRIED DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| unknown | | USA | | | | | | WICOMICO MD | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Salisbury | | 300 Newton Street | | | | | Painter | | | House painter | |
| 13a. STATE | | COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13b. STREET ADDRESS | | | |
| Maryland | | Wicomico | | Salisbury | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 300 Newton Street | | | |
| 14. FATHER'S NAME | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | | | | | |
| | | William | Richard | Kelley | Lillie | | MIDDLE | | Virginia | | LAST Griffin |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | (niece) | | ADDRESS | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Yes | | WW II | | 215-26-1861 | | Mrs. Norma L. Harris, | | 202 Chestnut St. Delmar, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410 - Coronary occlusion | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Heart disease years | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| Chronic alcoholism | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? | | | | |
| | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) John T. Bulkeley M.D. | | | | | MEDICAL EXAMINER | | | | |
| DATE SIGNED 8/26/79 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | John T. Bulkeley, M.D. | | | | | ADDRESS Salisbury, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY | | STATE | |
| Burial | | 8/27/79 | | Wango Cemetery | | Wango | | Wicomico | | Maryland | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| HOLLOWAY FUNERAL HOME | | Salisbury, Md. | | | | | AUG 29 1979 | | Victor McCreedy | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, BY TELEGRAPH, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, ONE PAGE 1, 2, AND 3 TO THE FUTURE DATE FOR WHICH FORM, PW, 3 RETAIN PAGE 3 FOR FUTURE USE. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM, PW, 3. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT; PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DPHMH - 17
IVR A15 ME (5)
15M 7/76



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be called at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 9 2 1 0 9 0 | |
|---|--|---|-----------------|---|---|------------------------------------|--|--|-----------------|---|--|----------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST WALTER | MIDDLE -- | LAST Kowalski | 2a DATE OF DEATH MONTH DAY YEAR | | | 2b HOUR 44 M | | | | |
| 3. SEX <i>Male</i> | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 24, 1912 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE STATE OR FOREIGN COUNTRY New Haven, Conn. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | | MD. | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Postal Employee | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| 13a. STATE Florida | | 13b. COUNTY Palm | | 13c. CITY OR TOWN Lakewood | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 1122 North D Street | | | |
| 14. FATHER'S NAME FIRST Stanley | | MIDDLE Kowalski | | 15. MOTHER'S MAIDEN NAME FIRST Wanda | | | 16. SOCIAL SECURITY NO. 044-12-2859 | | | 17. INFORMANT Mr. Robert J. Kowalski (son) | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Colorectal cancer of pancreas rectum</i> | | 1579 | | DUE TO, OR AS A CONSEQUENCE OF (b), (c) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/8/79</i> to <i>8/8/79</i> , that (I) (we) last saw the deceased alive on <i>8/8/79</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Wilber R. Ellis</i> | | 22c. DEGREE <i>D.M.D.</i> | | | ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d. DATE SIGNED <i>8-8-79</i> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wilber R. Ellis, Jr., M.D. | | 22e. ADDRESS Salisbury, Maryland | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8/11/79 | | 23c. NAME OF CEMETERY OR CREMATORIAL St. Lawrence Cemetery | | | 23d. LOCATION CITY OR TOWN West Haven, New Haven, Conn. | | | | | | |
| 24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Maryland | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR AUG 13 1979 | | | 25b. REGISTRAR'S SIGNATURE <i>John Holloway</i> | | | | | |

coincide

Intergovernmental Education Guidelines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 9 21091 | | | | | | | |
|--|--|--|---|--|--|--|--|--|---|--|--|--|--|--|---|--|--|-------------------------------------|--|
| 1 - FOR STATE REGISTRAR | | | 2a DATE OF DEATH MONTH DAY YEAR | | | | | | | | | 2b HOUR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | August 20 1979 | | | 9 20 AM | | | | |
| 3 SEX | | | 4 RACE | | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6 AGE IN YEARS LAST BIRTHDAY | | | 7 IF UNDER 1 YEAR MONTHS DAYS | | | 8 IF UNDER 24 HRS HOURS MIN | | | | |
| MALE | | | WHITE | | | SEPT. 13, 1908 | | | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | 70 YRS | | | | | | | |
| 7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7c CITIZEN OF WHAT COUNTRY? | | | 8 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | | 10 CITY OR TOWN OF DEATH Salisbury | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | |
| 13a STATE MD. | | | 13b COUNTY VICOMICO | | | 13c CITY OR TOWN SALISBURY | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e STREET ADDRESS 201 CHESTNUT WAY | | | 12a USUAL OCCUPATION RETIRED | | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 14 FATHER'S NAME FIRST GEORGE LEWIS | | | MIDDLE | | | LAST | | | 15 MOTHER'S MAIDEN NAME MARY GARDNER | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b SOCIAL SECURITY NO. 40 | | | 17 INFORMANT 214-10-7012 MRS. IRENE M. LEWIS | | | ADDRESS SALISBURY, MD. | | | | | | | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for 18a, b, and c PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last { b) Arterosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day years. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes, Renal renal carcinoma, Recurrent hematuria Cardiomegaly | | | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET | | | CITY OR TOWN | | | COUNTY | | | STATE | | | | |
| 22a I certify that (I) (we) attended the deceased from 8/20/79, 19, to 8/20, 19, that (I) (we) lost saw the deceased alive on 8/20/79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b SIGNATURE BAL AGARWAL | | | 22c DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/> | | | 22d DATE SIGNED | | | | | | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) BAL AGARWAL | | | 22e ADDRESS Peninsula General Hospital. | | | | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b DATE 8/23/79 | | | 23c NAME OF CEMETERY OR CREMATORIUM ST. JOHN CEMETERY | | | 23d LOCATION FRUITLAND, MD. | | | | | | | | | | |
| 24 FUNERAL DIRECTOR NAME WILSON FUNERAL HOME | | | ADDRESS SALISBURY, MD. | | | 25a DATE REC'D. BY REGISTRAR AUG 27 1979 | | | 25b REGISTRAR'S SIGNATURE MOSLEY, BRENDA | | | | | | | | | | |

cont tab 37

Estimated Estimated Maximum Number 1163

STXCSV

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 9 21092 | | | |
|--|--|--|------------------------------------|---|--|-------------------|---|--|----------------------------------|-----------------------------------|-------|--|--|-----------------------------------|--|
| 1 - STATE REGISTRAR | | | 1 DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | | |
| | | | Eta Marian Long | | | August 29 1979 | | | 11 47 AM | | | | | | |
| 3. SEX | | 4 RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN. | | | |
| F | | N | | 1-17-1905 | | | 74 YRS | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | |
| Maryland | | U.S.A. | | | | | WICOMICO | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HIGHEST FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| SALISBURY | | PENINSULA GENERAL HOSPITAL | | | | | | | | | | Secretary | | Legal | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | | | |
| Maryland | | Wicomico | | Salisbury | | | | | N. Park Garden Apts. | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | | | | | |
| Ira Edward Gordy | | Vesta Elizabeth Morris | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | 18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| No | | 216-14-2156 | | Mr. Creston S. Long | | | Salisbury Md | | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 3949 Cardiac Arrest/Arrhythmia | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) 50/50 Valve Disease | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | COUNTY | | STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6 19 78 to 8 1 79, that (I) (we) last saw the deceased alive on 8 1 79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE DEGREE | | | | | | | | | | | | 22c. DATE SIGNED 8/29-79 | | | |
| ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. L. Rafferty | | | | | | | | | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION CITY OR TOWN | | COUNTY | | STATE | | | | |
| Burial | | 9-1-79 | | Wicomico Park Memorial Salisbury | | | Wicomico | | Md. | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | | 25a. DATE REC'D. BY REGISTERED MAIL | | | 25b. REG'D. PAR'S SIGNATURE | | | | | | | |
| Holloway Funeral Home P.A. Salisbury, Maryland | | | | | SEP 4 1979 | | | Brendy | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be used as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be held within 7 days of death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. |
|--|--|--|---|--|--|--|--|--|---|--|--|----------|
| 1. FOR STATE REGISTRAR | | | 9 21093 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | | |
| MERRITT PAUL Marsh | | | | | | August 9, 1979 | | | 10 ³⁵ PM | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | |
| M | | | W | | | JAN 12 1940 | | | 39 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| VIRGINIA | | | U.S.A. | | | | | | Wicomico | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Salisbury | | | Peninsula General Hospital | | | MAINTENANCE | | | POSTAL SERVICE | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| MD | | | DORCHESTER | | | CAMBRIDGE | | | 13e. STREET ADDRESS 325 WILLIS ST | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | |
| MERITT R. MARSH | | | MARGARET PAUL | | | 57750-4584 | | | Mrs BARBARA MARSH SAME AS 13 | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c. PART I. DEATH WAS CAUSED BY: | | | IMMEDIATE CAUSE (a) <u>Gastro-esophageal Bleeding</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| 5715- | | | DUE TO, OR AS A CONSEQUENCE OF (b) <u>Portal Hypertension</u> | | | 9 Days | | | | | | |
| Conditions, if any, which gave rise to immediate cause (1a), stating the underlying cause, if any. | | | DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cirrhosis</u> | | | d months | | | | | | |
| years | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | |
| Alpha one Anti Trypsin Deficiency | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (we) attended the deceased from 7/31, 1979, to 8/9, 1979, that (I) (we) lost sow the deceased alive on 8/9, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <u>J.O. meadows</u> | | | DEGREE <u>M.D.</u> | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 8/9/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J.O. meadows M.D.</u> | | | 22e. ADDRESS <u>Suite 31 Wesley Drive Salisbury Maryland</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE 8-10-79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Del Marva Crematory | | | 23d. LOCATION CITY OR TOWN LEWES COUNTY SUSSEX STATE DELAWARE | | | |
| CREMATION | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Curran Funeral Home | | | ADDRESS 308 HIGH ST CAMBRIDGE, MD | | | 25a. DATE REC'D. BY REGISTRAR AUG 15 1979 | | | 25b. REGISTRAR'S SIGNATURE <u>Larry Murphy</u> | | | |

500 ft. + 200 ft.

depth

at 100 ft.

coconut

Indigo Internal structures

grinding

100 ft.

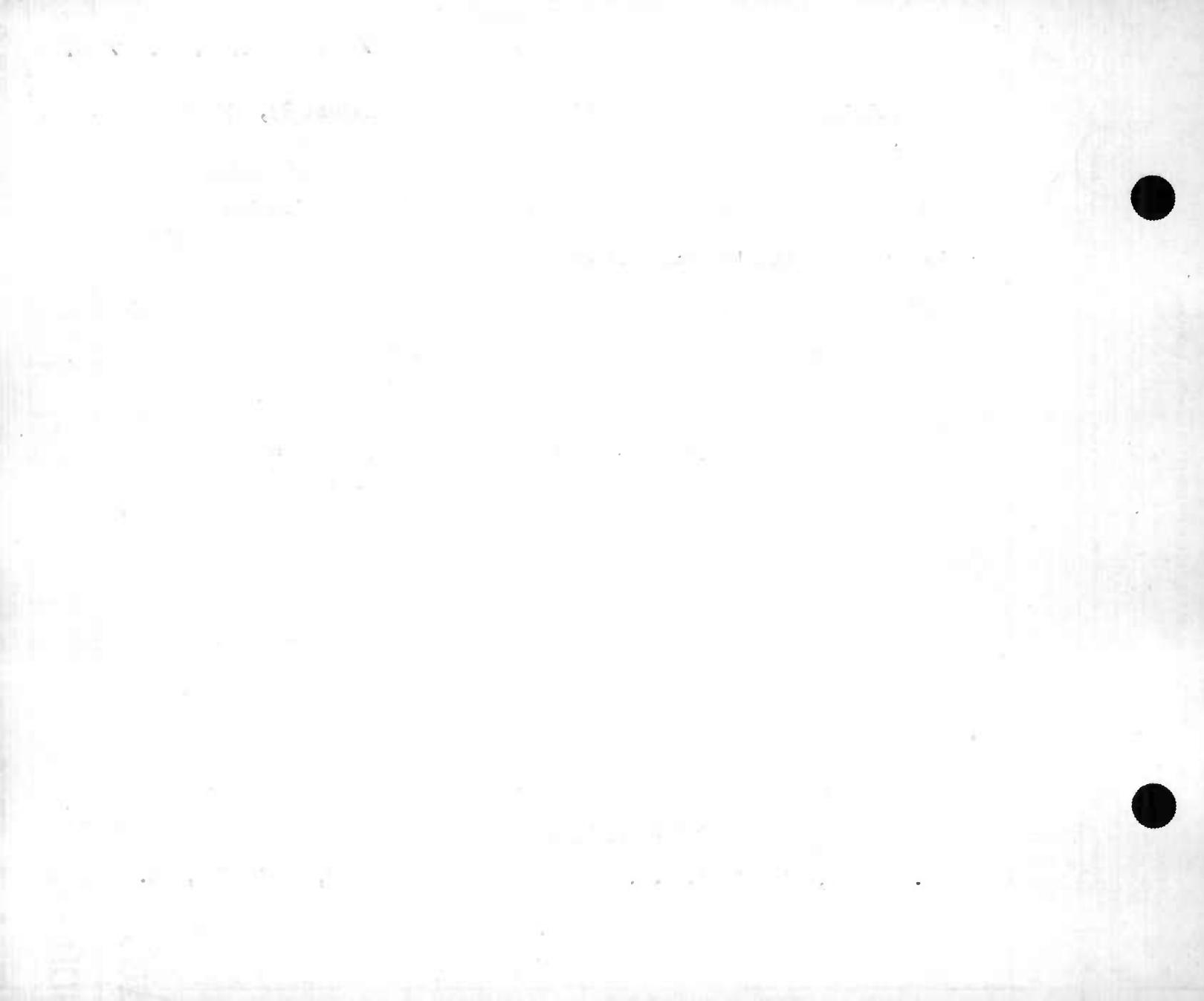
TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death.

X
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | 9 | 2 | 1 | 0 | 9 | 4 | | |
|---|--|--|-------|---|--|---|---|--|---------------------|---|-----------------------------------|---|------|
| | | | | | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | |
| Nellie | | | | | McALLEN | August 23, 1979 | | | | | | 5:15 am | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| F | | C | | APR. 23 1902 | | 77 | | | YRS | MONTHS | DAYS | HOURS | MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | | |
| NJ | | USA | | | | Wi.comico | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Salisbury | | Deer's Head Center | | | | | | Domestic | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS | | | | |
| Md | | Wic | | Salis. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 1102 West Road | | | | |
| 14. FATHER'S NAME FIRST | | MIDDLE | | LAST | 15. MOTHER'S MAIDEN NAME FIRST | | | MIDDLE | | LAST | | | |
| unk | | | | | unk | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | ADDRESS | | | | | | |
| 16a. YES | | | | Thelma | | | Butler | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY | | IMMEDIATE CAUSE (a) <i>Carcinoma of breast - metastasis</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 18. 1949 | | DUE TO, OR AS A CONSEQUENCE OF (b) <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last</i> | | | | | | | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | COUNTY | STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | | | | | | | | |
| E. Peyton, Ritchings, M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. DATE SIGNED 8/23/79 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIAL GREEN ACRES MEM PARK | | | 23d. LOCATION CITY OR TOWN Salis. | | COUNTY Wic | STATE Md | | | |
| Burial | | 8-27-79 | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| West - Books F/H | | Salisbury Md. | | SFP 7 1979 | | | Lester LeBarney | | | | | | |
| DHMH-16 20M (VRA 15, 4) 7/78 | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | 9 | 2 | 1 | 0 | 9 | 5 |
|--|--|---|--|--|--------|--|---------------------------------|------|---|-----------------------------------|-------|--|----------|--------------------------------------|----------|---|---|
| | | | | | | | | | | | | REG. NO. | | | | | |
| 1 - FOR STATE REGISTRAR | | | 1 DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | | |
| | | | James | | | Millard | McCANN | | August 15, 1979 | | | | | | M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | |
| Male | | White | | Month Day Year Oct. 3, 1887 | | | 91 | | | MONTHS DAYS | | HOURS MIN | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 | | | 9 | | | BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| N. Carolina | | USA | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 91 YRS | | | WICOMICO MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Salisbury | | River Walk Nursing Home | | | | | | | | | | Farmer | | Farming | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | 13a. STATE Maryland | | | | | |
| | | | | | | | | | | | | 13b. COUNTY Wicomico | | | | | |
| | | | | | | | | | | | | 13c. CITY OR TOWN Fruitland | | | | | |
| 14. FATHER'S NAME | | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | | FIRST | MIDDLE | LAST | (unknown) | | | | | |
| James | | | | | McCann | Polly | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT (daughter) ADDRESS | | | Rt. 7 | | | | | | | | |
| NO | | | 212-16-1655 | | | Mrs. Bonnie Hammond, Salisbury, Md. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| IMMEDIATE CAUSE (a) cerebral thrombosis 4340 | | | | | | | | | | | | 10 hrs | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | (b) Cerebralized arteriosclerosis 4/25 | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | Diseased cerebrovascular accident | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | COUNTY | STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-11 19-76 to Aug 15, 1979, that (I) (we) lost saw the deceased alive on Aug 14, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | | | | | | | |
| John T. Bulkeley M.D. | | | | | | | | | 8-15-79 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | | | | | | | | | | | |
| John T. Bulkeley, M.D. | | | Salisbury, Md. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION CITY OR TOWN | | | COUNTY | STATE | | | | |
| Burial | | | 8/17/79 | | | Nicomico Memorial Park | | | Salisbury | | | Wicomico | Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |
| Holloway Funeral Home, Salisbury, Md. | | | | | | | | | AUG 21 1979 | | | Holloway | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

retd by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at date _____.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 9 2 1 0 9 6 | | | | | | |
|---|--|--|---|--|--|--|--------|--------|---|--|----------------------------|-----------------------------|------|---|------------------------|--|
| | | | | | | | | | | REG. NO. | | | | | | |
| 1 - STATE REGISTRAR | | | 1 DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 7a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | | | |
| | | | Joshua | | | | | McPHEE | August 5, 1979 | | | 8:30 A | | | | |
| 3 SEX | | | 4 RACE | | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | | | |
| Male | | | B.I.K. | | | April 15 1903 | | | 76 yrs. | | | MONTHS | DAYS | IF UNDER 24 HRS | | |
| 7a. BIRTHPLACE STATE OR FOREIGN COUNTRY | | | 7b. CITIZEN OF WHAT COUNTRY? | | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Miami, Florida | | | U.S.A. | | | | | | Wicomico Co | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Salisbury | | | Deer's Head Center | | | Farmer-Poultry | | | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS Rt. Box 19 Marion, Md. | | |
| 13a. STATE Md. | | | 13b. COUNTY Somerset | | | 13c. CITY OR TOWN Marion | | | | | | | | | | |
| 14 FATHER'S NAME Unknown | | | MIDDLE | | | 15. MOTHER'S MAIDEN NAME Unknown | | | 16. SOCIAL SECURITY NO. 215-32-0174 | | | 17. INFORMANT J.B. Green | | | ADDRESS Marion, Md. | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. | | | 16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adeno carcinoma of lung | | | | | | | | | | | | | | | | |
| 16d. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | | | | |
| 16e. (b) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | |
| 16f. (c) _____ | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY | | STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE L. V. Maldve, M.D. | | | | | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 8/5/79 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. V. Maldve, M.D. | | | | | | | | | | 22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE Aug 8, 1979 | | | 23c. NAME OF CEMETERY OR CREMATORIUM Liberia | | | 23d. LOCATION CITY OR TOWN Marion Sta., Somerset | | | COUNTY | | STATE Md. | | |
| 24. FUNERAL DIRECTOR NAME Norman Ward | | | ADDRESS Marion St., Md. | | | 25a. DATE REC'D. BY REGISTRAR AUG 6 1979 | | | 25b. REGISTRAR'S SIGNATURE Larry McElroy | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. | | | | | | | |
|---|--|--|--|--|--|-----------------------------------|---|---|-------------------------|--------------|--|--|--------------------------------|--|-------------------------------|-----------------------------------|--|----------------------------|--|
| 1 - FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | | | | 2b. HOUR 150 PM | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | | | | 2b. HOUR 150 PM | | | | |
| WILLIAM JAMES MILES | | | | | | | AUGUST 11 1979 | | | | | | | | 150 PM | | | | |
| 3. SEX | | | | 4 RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | | | |
| male | | | | white | July 25, 1919 | | | 60 YRS. | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | 8 | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | MD. | | | | | | |
| Maryland | | | | USA | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | Wicomico | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Salisbury | | | | Peninsula General Hospital | | | | | | | | electrician | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET ADDRESS | | | | | | |
| Maryland | | | | Worcester | Pocomoke | | | | | | | | Walnut Street | | | | | | |
| 14. FATHER'S NAME FIRST | | | | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT ADDRESS | | | | | |
| Mark | | | | P. | Miles | Blanche | | | 222-10-9543 | | | | | Box 8, Route #1 Russell Carter Pocomoke City, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| 5771 Septic malnutrition | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | DUE TO, OR AS A CONSEQUENCE OF (b) <u>multiple Abscesses</u> | | | | | | | | | | | | | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ovarian Peritonitis</u> | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | COUNTY | STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 19 79 to Present, 19 , that (I) (we) last saw the deceased alive on 8/11 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | | | | | | | | | 22c. DATE SIGNED | | | |
| J.S. meadows m.d. | | | | | | | | | | | | | | | | 8/11/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | | | | | | |
| J.S. meadows m.d. | | | | Sue 31 Wesley Drive Salisbury MD 21801 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | | | 23d. LOCATION CITY OR TOWN | | COUNTY | STATE | | | | |
| Burial | | | | 8/15/79 | | | St. Mary's Epis. Cem. Pocomoke | | | | | Worcester | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Scott S. Milson | | | | Pocomoke City, Md. | | | | | | | | | | | | AUG 15 1979 | | Victor McElroy | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 18 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 9 21098 | |
|---|--|--|---|--|--|---|--|--|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR | | | 1a. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | |
| | | | GRACE DUFFY MILLER | | | | | | AUGUST 19 1979 | | | 245 PM | |
| 3 SEX | | | 4 RACE | | | 5 DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR IF UNDER 24 HRS | |
| FEMALE | | | WHITE | | | DEC 31, 1920 | | | 58 | | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | YRS | |
| VIRGINIA | | | U.S.A. | | | | | | Wicomico | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | MD. | |
| Salisbury | | | Peninsula General Hospital | | | | | | BUSINESS OFFICE REP. | | | C & P | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS | |
| MARYLAND | | | PRINCE GEO | | | W. HYATTSVILLE | | | | | | 6306 23rd AVENUE | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | |
| FIRST FREDERICK MIDDLE DUFFY | | | MIDDLE MARY A. LAST DeSANTIS | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| NO | | | 578-07-1913 | | | ROBERT L. B. MILLER | | | SAME AS 13 HUSBAND | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure | | | | | | | | | | | | | |
| 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Colon carcinoma & liver metastasis | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | | P.M. 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | COUNTY STATE | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 8/13/79 to 8/19/79, that (I) <input type="checkbox"/> lost sight of the deceased alive on 8/18/79, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) (we) <input type="checkbox"/> did not view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Joseph A. Grasso | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | | | |
| 22e. ADDRESS PENINSULA GENERAL HOSPITAL SALISBURY MD 21801 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE 8/22/79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL GATE OF HEAVEN | | | 23d. LOCATION CITY OR TOWN SILVER SPRING | | | COUNTY MONT STATE MD. | |
| BURIAL | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR FRANCIS J. COLLINS | | | ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | 25a. DATE REC'D. BY REGISTRAR AUG 28 1979 | | | REGISTRAR'S SIGNATURE | | | Bobby McBrady | |
| | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. | |
|--|--|--|--|------------------------------------|-----------------|---|---------------------------------|--|---|--|--|-----------------------|--|
| 1. FOR STATE REGISTRAR | | | 2d. DATE OF DEATH MONTH DAY YEAR | | | | | | | | | 2b. HOUR 2:30 P.M. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2d. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR 2:30 P.M. | | | | |
| BESSIE P. | | | | | Mitchell | August 8 1979 | | | 2:30 P.M. | | | | |
| 3. SEX | | | 4 RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | | |
| Female | | | WHITE | DEC. 31, 1895 | | | 83 | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| MARYLAND | | | USA | | | | | | Wicomico | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Salisbury | | | Peninsula General Hospital | | | HOUSE WIFE | | | OWN HOME | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13b. STATE | | | 13c. COUNTY | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS | | | | |
| MARYLAND | | | WORCESTER | | | | | | R.P. | | | | |
| 14. FATHER'S NAME | | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | | 16. ADDRESS | | | | |
| JACOB W. POWELL | | | | | | ANNIE COLLINS | | | POWELL MITCHELL WHALEYVILLE, MD | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| (If Yes, give war or dates) | | | 213-74-4919 | | | | | | and died also see Heart disease certificate | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b) and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | | | | | | | | | | | |
| 4140 | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | COUNTY | STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-31 , 19 79 , to 8-8 , 19 79 , that (I) (we) last saw the deceased alive on 8-8 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | |
| Wilber R. Ellis | | | | | | | | | Kay Drive Salisbury Maryland | | | 8-8-79 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION CITY OR TOWN | | | | |
| BURIAL | | | 8-11-79 | | | DALE | | | WHALEYVILLE WORCESTER, MD | | | | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Peter Whaley SELBYVILLE, DEL. | | | | | | AUG 13 1979 | | | Hector McBrady | | | | |

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Digitized by srujanika@gmail.com

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be left blank by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must benefit from the protection of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 9 2 1 1 0 0 | | | |
|--|--|---------------------------------------|--|---|--|---|--|----------------------------------|--|---|--|---|-------|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | | | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ELSIE | | | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | | | | |
| Female | | white | | 6/16/1921 | | 51 yrs | | | | | | | | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | | | 10. CITY OR TOWN OF DEATH Salisbury | | | | | |
| Maryland | | U. S. | | | | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital | | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | Poultry | | 13a. STATE Maryland | | 13b. COUNTY Somerset | | 13c. CITY OR TOWN Princess Anne | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Route 3 | |
| 14. FATHER'S NAME FIRST Walter | | MIDDLE Kohlheim | | 15. MOTHER'S MAIDEN NAME Sarah | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Tracy Grangier, Princess Anne | | 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Breast Cancer | | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 1749 | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | (b) | | | | | | | | | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | COUNTY | | STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/11/79 to 8/12/79, that (I) (we) lost saw the deceased alive on 8/11/79 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | | | 22b. DATE SIGNED 8-12-79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Grasso | | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/13/79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL All Saints Monue | | | 23d. LOCATION Cemetery Princess Anne; Somerset; Md | | | |
| 24. FUNERAL DIRECTOR NAME James L. Henman | | | ADDRESS Princess Anne | | | 25a. DATE REC'D. BY REGISTRAR AUG 16 1979 | | | 25b. REGISTRAR'S SIGNATURE Lillian McCready | | | | | | |
| BP | | | | | | | | | | | | | | | |
| DHMH - 16 60M 1/75 (VR A 15 (4)) | | | | | | | | | | | | | | | |

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Items 5,6 g534 8/28/79 gj MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

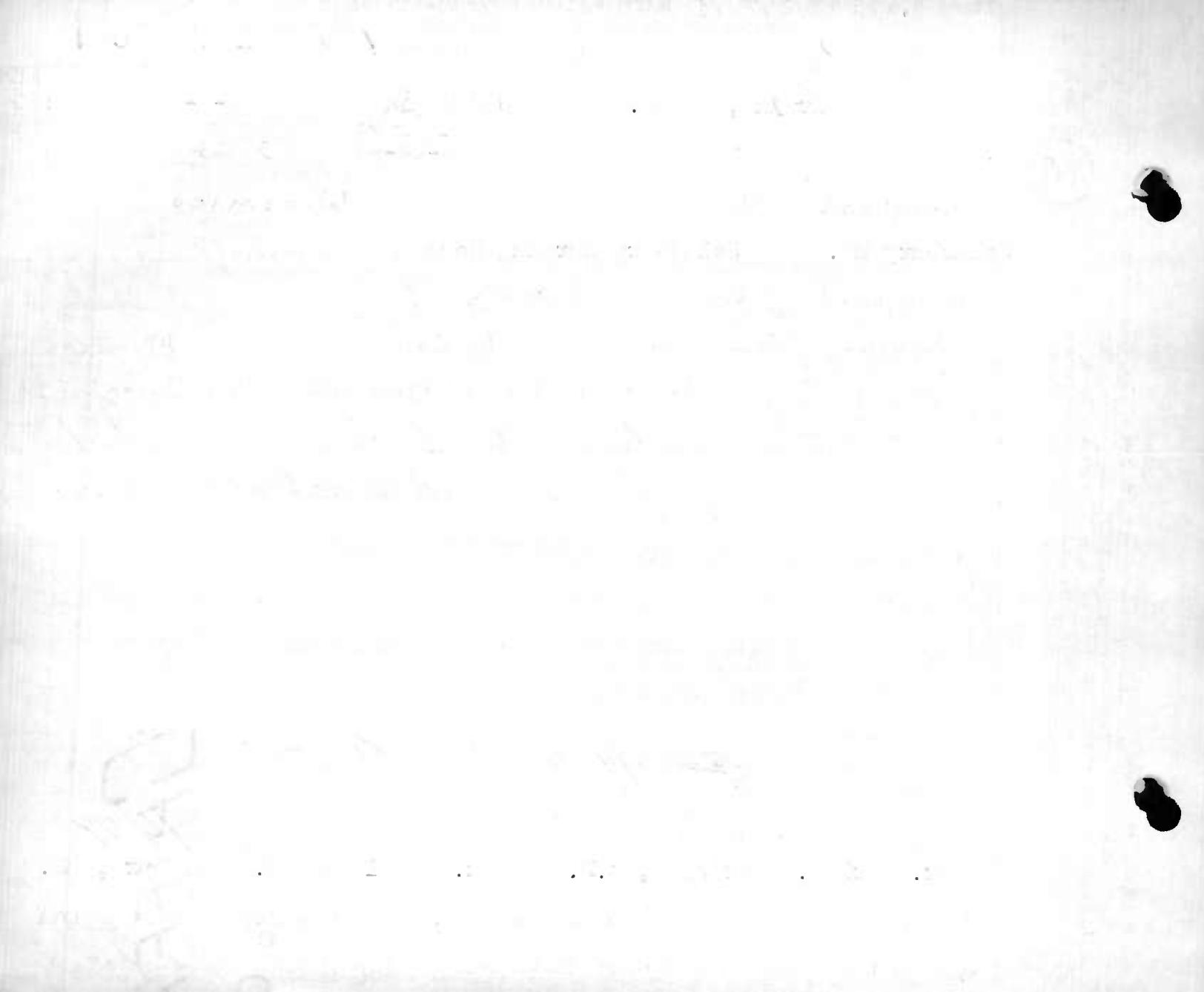
CERTIFICATE OF DEATH

291 101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the State Dept. of Health prior to burial, cremation, or removal, and any event within 24 hours after death.

| | | | | | |
|--|--|--|--|---|---------------------------|
| 1. DECEASED-NAME (Type or print) | First | Middle | Lost | 20. DATE OF DEATH Month Day Year | 2b. HOUR PM |
| Irving, S. | | MUMFORD, JR. | | 8-4-79 | 7:40M |
| 3. SEX | 4. RACE | S. DATE OF BIRTH 4-18-1894 6-18-94 | 6. AGE (In years last birthday) 85 yrs. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| M | W | | | | |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | 9. COUNTY OF DEATH Wicomico | | |
| 10. CITY OR TOWN OF DEATH Salisbury Md. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Salisbury Nursing Home | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Merchant MARINES | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | 13b. COUNTY WORCESTER | 13c. CITY OR TOWN OCEAN CITY | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME IRVING STURGIS Mumford | 15. MOTHER'S MAIDEN NAME Louisa | Middle | Lost | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | 16b. SOCIAL SECURITY NO. 218-14-6848 | 17. INFORMANT IRVING S. Mumford III | Address RT 1 OCEAN CITY, MD. | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Tute. 2 yrs. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac thrombosis</i> <i>#340</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>generalized arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County State |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/3</i> , 19 <i>78</i> , to <i>5/14</i> , 19 <i>78</i> , that (I) (we) last saw the deceased alive on <i>4/14/78</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE <i>Dr. Earl M. Beardsley, M.D.</i> | | ATTENDING PHYS. <i>Dr. Earl M. Beardsley, M.D.</i> | MED. DIRECTOR <input checked="" type="checkbox"/> <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED <i>8/6/79</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 8/7/79 | 23c. NAME OF CEMETERY OR CREMATORIAL EVERGREEN Cem. | 23d. LOCATION (City or Town) BERLIN | (County) WOR. (State) MD. |
| 24. FUNERAL DIRECTOR <i>Jean B. Prettyman</i> | | ADDRESS 108 Wm St. Berlin, Md. | 25a. REC'D BY REGISTRAR DATE AUG 13 1979 | 25b. REGISTRAR'S SIGNATURE <i>Hilary McCreedy</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 must be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the Burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 19 21102 | | | |
|--|--|---|-------------------------------------|---|---|---------------|--|---|-------------------------------------|-------------------|-------|----------------|--|
| 1 - FOR STATE REGISTRAR | | | I. DECEASED NAME (TYPE OR PRINT) | | | LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | |
| John Edward Mumford | | | | | | Jan. 28, 1921 | | | AUGUST 5 1979 | | | 9 A.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF OVER 1 YEAR | |
| male | | Black | | Jan. 28, 1921 | | | 58 | | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE STATE OR FOREIGN COUNTRY | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | | MD. | | | |
| Maryland | | U.S.A. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) net. construction worker | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Md. Wor. | | Bishopsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS R.D. 1 Box 142 | | | | | | |
| 14. FATHER'S NAME Henry Mumiford | | 15. MOTHER'S MAIDEN NAME Hallie Walters | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) np | | 17. INFORMANT Margaret A. Mumford, Bishopsville, Md. | | | ADDRESS | | | | | | |
| | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for item 18 and item 21. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sept census 5198 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) Probable respiratory infection DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18 Homeborn & recently removed from R. home | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | | | | |
| | | | | | | | | COUNTY | | | STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from show the deceased alive on 8/5/79 to 7/10/79, and that in my (or) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS KAY AVE SALISBURY MD. 21801 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8/9/79 | | 23c. NAME OF CEMETERY OR CREMATORIAL Curtis Mem. Cem. | | | 23d. LOCATION CITY OR TOWN Bishopsville, Wor. Co., Md. | | | COUNTY | | STATE | |
| 24. FUNERAL DIRECTOR NAME Richard T. Watson | | ADDRESS Sallyville, Del. | | 25a. DATE REC'D. BY REGISTRAR AUGO 8 1979 | | | 25b. REGISTRAR'S SIGNATURE Loyalty Helmsley | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | 9 | 2 | 1 | 1 | 0 | 3 | |
|--|--|--|--|--|--|--|--|--|---|--|--|---|---|-------------------------|-----|-------|---------|--|
| | | | | | | | | | | | | REG. NO. | | | | | | |
| 1 - FOR STATE REGISTRAR | | | 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LOUISE E. | | | LAST MUMFORD | | | 2a DATE OF DEATH | | MONTH | DAY | YEAR | 2b HOUR | |
| 3 SEX <i>female</i> | | | 4 RACE <i>Black</i> | | | 5. DATE OF BIRTH MONTH <i>Oct.</i> DAY <i>14</i> YEAR <i>1918</i> | | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. | | | IF UNDER 1 YEAR MONTHS | | IF UNDER 24 HRS DAYS | | HOURS | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | | 7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>WICOMICO, MD.</i> | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH <i>SALISBURY</i> | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>DEER'S HEAD CENTER</i> | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housewife</i> | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| 13a STATE <i>Delaware</i> | | | 13b COUNTY <i>Sussex</i> | | | 13c CITY OR TOWN <i>Selbyville</i> | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e STREET ADDRESS <i>R.D. 2 Box 87-6</i> | | | | | | |
| 14 FATHER'S NAME <i>Charles H. Jones</i> | | | 15. MOTHER'S MAIDEN NAME <i>Anna Mae Jarman</i> | | | | | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i> | | | 16b SOCIAL SECURITY NO. <i>222-09-2208</i> | | | 17. INFORMANT <i>Alex Mumford - Selbyville, Delaware</i> | | | ADDRESS | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>1809</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN INJURY AND DEATH <i>> 4</i> | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) <i>Adeno-epidermial carcinoma Gastric metastasis</i> | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? | | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <i>Jun 27, 1979</i> , to <i>Aug. 03, 1979</i> , that (we) last saw the deceased alive on <i>Aug. 03, 1979</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>L. V. Maldve</i> | | | 22c. DEGREE <i>MD.</i> | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d. DATE SIGNED <i>08/03/79</i> | | | | | | | | | |
| 22e. ADDRESS <i>Deer's Head Center, Salisbury, Md. 21801</i> | | | | | | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | 23b. DATE <i>8/7/79</i> | | | 23c NAME OF CEMETERY OR CREMATORIAL <i>Curtis Memorial Cem.</i> | | | 23d. LOCATION CITY OR TOWN <i>Bishopsville, Wor. C., Md.</i> | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>Richard T. Watson</i> | | | ADDRESS <i>Millsboro, Del.</i> | | | 25a. DATE REC'D. BY REGISTRAR <i>AUG 07 1979</i> | | | 25b. REGISTRAR'S SIGNATURE <i>J. Bradley</i> | | | | | | | | | |

normal, non-ionic
surfactant - benzyl alcohol 655-10-55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, or by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours until death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 9 2 1 1 0 4 | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|--------------------------------------|-------|--|--|--|------|--|-------------------|------------------------------|---|---------------------------------------|------------------------|--|--|--|----------------------------|--|---|---|--|---|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | 1. DECEASED NAME (TYPE OR PRINT) | | | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | | | | | | | | | | | | | | | |
| | | | WILLIAM STANLEY MURRAY | | | | | | | | | | August 13, 1979 | | | | | 3 40 AM | | | | | | | | | | | | | | | |
| 3 SEX | | | 4 RACE | | | 5 DATE OF BIRTH | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 7c. MARRIED WIDOWED | | | 7d. NEVER MARRIED DIVORCED | | 7e. IF UNDER 18 YEARS MONTHS DAYS HOURS MIN | | | | | | | | | | | |
| Male | | | White | | | Oct. 14, 1910 | | | 68 | | | Maryland | | USA | | | | | | | | | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | 13. ADDRESS | | | | | | | | | | | | | | | |
| Salisbury | | | Peninsula General Hospital | | | | | | | | | Contractor | | | Construction | | | MD. | | | | | | | | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | | | | | | | | | | | | |
| | | | | | | | | | | | | Maryland | | Wicomico | | Salisbury | | | | 200 Francis Drive | | | | | | | | | | | | | |
| 14 FATHER'S NAME | | | FIRST MIDDLE LAST | | | 15 MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | | | | | | | | | | | | |
| John | | | Samuel Murray | | | May Belle Taylor | | | Yes WW II | | | 214-10-9424 | | | Mrs. Sandra M. Crouch (daughter) | | | 200 Francis Dr., Salisbury, Md. | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18, 1b, and c) PART I. DEATH WAS CAUSED BY | | | | | | | | | | | | IMMEDIATE CAUSE (a) Acute Lymphocytic Leukemia | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| 2040 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) | | | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from 8/13/79 to 8/13/79, that (I) we lost saw the deceased alive on 8/1/79, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did <input checked="" type="checkbox"/> not view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Joseph A. Grasso</i> | | | 22c. DEGREE MD | | | | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d. DATE SIGNED 8-13-79 | | | | | | | | | | | | | | | | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | | | 22f. ADDRESS | | | | | | | | | | | | | | | | | | | | | |
| Joseph A. Grasso | | | | | | | | | | | | MD | | | Salisbury, Maryland | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION CITY OR TOWN | | | 23e. COUNTY | | 23f. STATE | | 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | |
| Burial | | | 8/16/79 | | | Wicomico Mem. Park | | | Salisbury | | | Wicomico | | Maryland | | HOLLOWAY FUNERAL HOME, Salisbury, Md. | | AUG 16 1979 | | | <i>Hilary McCloskey</i> | | | | | | | | | | | | |

on hand

Indicate above dimensions in inches

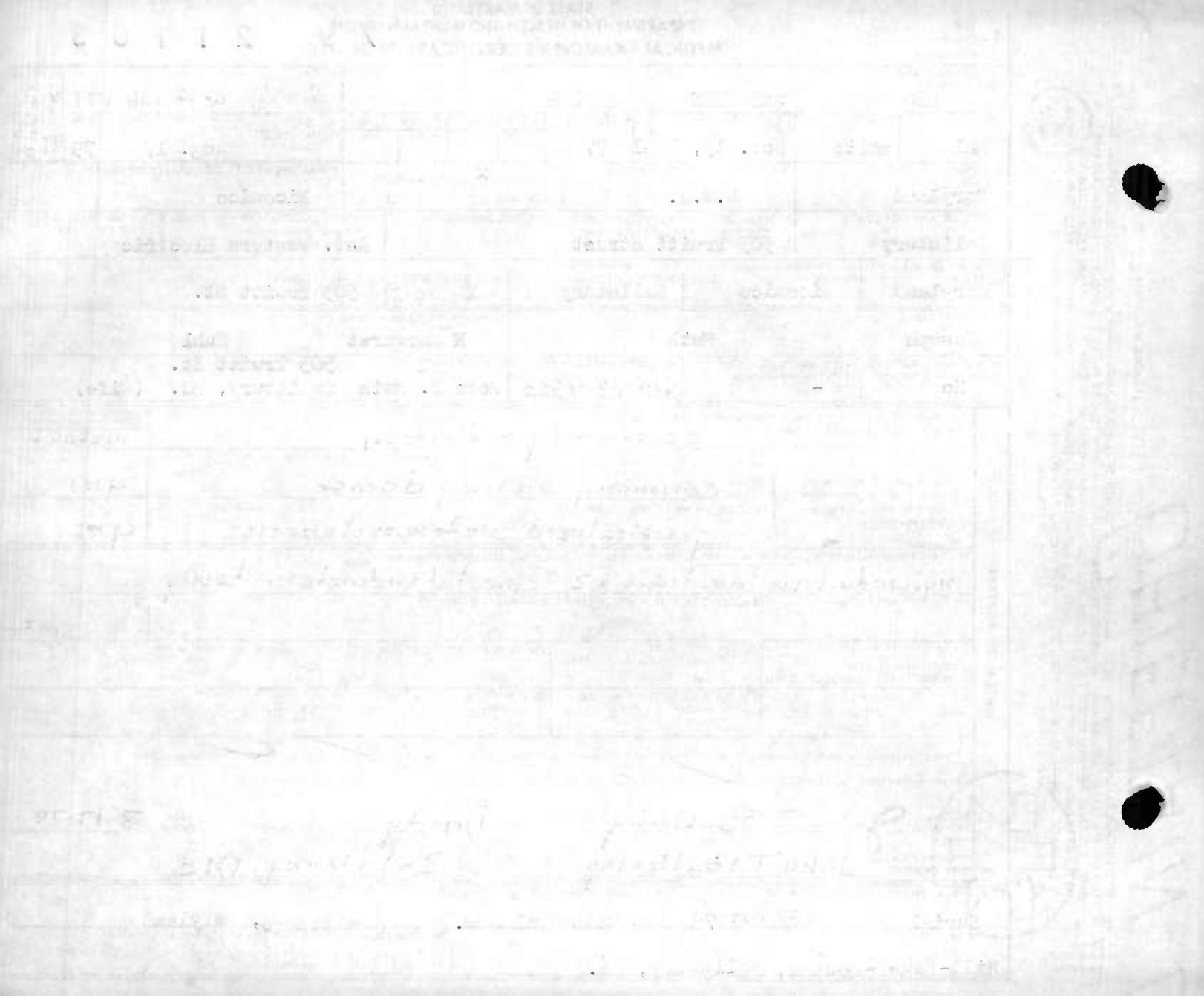
5
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21105
REG. NO.FOR
1 - STATE
REGISTRAR

| | | | | | | | | | | | | |
|---|-------------|--|---|-------------------------------|---|---|--------------------------------------|-------------------------------|-----------------------|----------------------------|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF ESTI- DEATH MATED | MONTH | DAY | YEAR | 2b. HOUR | | |
| LEO | | | SEBASTIN | MUTH | | Aug 16 | 19 | 79 | 12 | | | |
| 3. SEX | 4 RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD | MONTH | DAY | YEAR | 2d. HOUR | | |
| Male | White | Nov. 15, 1901 | 77 yrs. | | | Aug. 17 | 19 | 79 | 11 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | | Wicomico | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Salisbury | | 503 Truitt Street | | | | | Ret. Western Electric | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | | | | |
| Maryland | Wicomico | Salisbury | | | 503 Truitt St. | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | |
| Joseph Muth | | | Margaret Kuhl | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | 503 Truitt St. | | | |
| No | | | 215-24-4355 | | | Rose D. Muth | | | Salisbury, Md. (Wife) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 410- IMMEDIATE CAUSE (a) coronary occlusion APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF instant | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery disease 4 yrs | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) generalized arteriosclerosis 4 yrs | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). myocardial infarctions x3 carotid endarterectomy | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | | | | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) M.D. | | | EXAMINER'S NAME (TYPE OR PRINT) | | | | | | DATE SIGNED | |
| John T Bulkeley | | Deputy | | | John T Bulkeley | | | | | | 8-17-79 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | ADDRESS | | | | | | | |
| John T Bulkeley | | | | | Salisbury, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION CITY OR TOWN | | COUNTY | STATE | |
| Burial | | 8/20/1979 | | | New Cathedral Cem. | | | Baltimore, Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Hill-Baker-Bounds | | Salisbury, Md. | | | | | | AUG 21 1979 | | John McElroy | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILE.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME (5))
15M 7/77

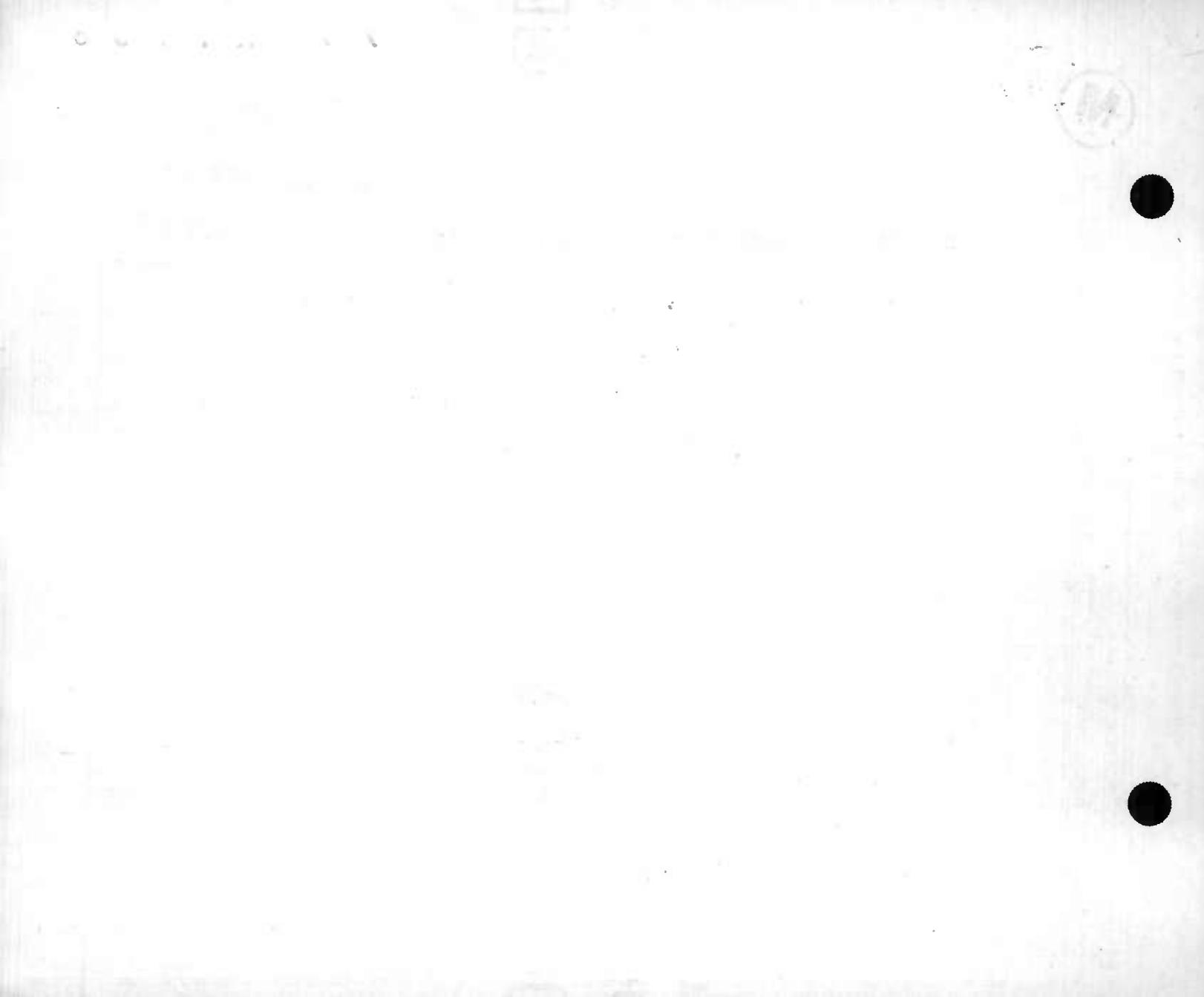


TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 9 2 1 1 0 6 | | | | | |
|--|--|--|---|-------------|---|--|--|--|---|---------------------------------------|--|---|--|---|--|--|--|
| 1 - STATE REGISTRAR | | | 2a DATE OF DEATH MONTH DAY YEAR AUGUST 30 1979 | | | | | | | | | 2b HOUR 30 PM | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 6a DATE OF DEATH MONTH DAY YEAR | | | 6b AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS YRS | | | 6c IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | | | |
| Olin Charles NEWELL | | | | | | AUGUST 30 1979 | | | 56 | | | | | | | | |
| 3 SEX | | | 4 RACE | | 5 DATE OF BIRTH MONTH DAY YEAR | | | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 8a CITIZEN OF WHAT COUNTRY? | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| M | | | W | | 12-4-1922 | | | New Hampshire U.S.A. | | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | WICOMICO | | | |
| 10 CITY OR TOWN OF DEATH SALISBURY | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PENINSULA GENERAL HOSPITAL | | | | | | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b KIND OF BUSINESS OR INDUSTRY N.F.C. Co. | | |
| 13a USUAL RESIDENCE IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION 13a STATE Maryland | | | 13b COUNTY Wicomico | | 13c CITY OR TOWN Salisbury | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e STREET ADDRESS 117 Johnson Dr. | | | | | | | |
| 14 FATHER'S NAME FIRST James Arthur | | | MIDDLE | LAST Newell | 15. MOTHER'S MAIDEN NAME FIRST Rose Mary | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | 16b SOCIAL SECURITY NO. 10-1945 td 042-16-5494 | | | 17. INFORMANT ADDRESS Mrs. Dorcas L. Newell 117 Johnson | | | |
| 18b APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | PART I. DEATH WAS CAUSED BY | | | IMMEDIATE CAUSE (a) Respiratory Inflammation | | | 1539 | | | DUE TO, OR AS A CONSEQUENCE OF (b) Olin Lenerman - Epidemic Con | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET | | | CITY OR TOWN | | | COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/15 19 29 to 8/30 19 29, that (I) (we) last saw the deceased alive on 8/29 19 29, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Joseph A. Grasso | | | 22c. DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d. DATE SIGNED SEP 4 1979 | | | | | | | | |
| 22e ADDRESS | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE 9-2-79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Mardela Cemetery | | | 23d. LOCATION CITY OR TOWN Mardela | | | COUNTY Wic. | | | STATE Md. | | |
| 24 FUNERAL DIRECTOR NAME Holloway Funeral Home P.A. Salisbury, Md. | | | ADDRESS | | | 25a DATE REC'D. BY REGISTRAR SEP 4 1979 | | | 25b. REGISTRAR'S SIGNATURE Troy McCreedy | | | | | | | | |
| DHMH-16 20M (VRA 15, 4) 7/78 | | | | | | | | | | | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILE.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 21107 | | |
|--|--|--------|--|-----------------------------------|---------------------------------------|---|---|-------------------------------|---|-------------------------------|--------|---|----------|---------------------------|
| 1- STATE REGISTRAR | | | FIRST | | | MIDDLE | | | LAST | | | 2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | ETHEL | | | LEVINIA | | | OLIPHANT | | | 2c. DATE ESTI- MATED <input checked="" type="checkbox"/> 8-10-79 | 1 A | |
| 3. SEX | | 4 RACE | | 5 DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 2d. DATE PRONOUNCED MONTH DAY YEAR | | 2d. HOUR 8-10-79 19 9:20A |
| Female | | White | | 3 23 08 | | 71 yrs. | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Mt. Vernon, Md.</i> | | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i> | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Salisbury</i> | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>712 Hammond St.</i> | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>none</i> | | | | | |
| 13a. STATE <i>Md.</i> | | | 13b. COUNTY <i>Wicomico</i> | | 13c. CITY OR TOWN <i>Salisbury</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS <i>712 Hammond St.</i> | | | | | |
| 14. FATHER'S NAME FIRST <i>Adolphus</i> | | | MIDDLE <i>White</i> | | | 15. MOTHER'S MAIDEN NAME FIRST <i>Mary</i> | | | MIDDLE <i>Levinia</i> | | | LAST <i>Muir</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i> | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS same as 13 | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>years</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <i>4029</i> | | | IMMEDIATE CAUSE (a) <i>Hypertensive Cardiovascular Disease</i> | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | (b) | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Earl L. Royer</i> TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER | | | | | | | | | | | | | | |
| DATE SIGNED 8-10-79 | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>Earl L. Royer, M.D.</i> | | | ADDRESS <i>409 Camden Ave., Salisbury, Md.</i> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | 23b. DATE <i>8/13/79</i> | | | 23c. NAME OF CEMETERY OR CREMATORIAL <i>Parsons Cemetery</i> | | | 23d. LOCATION CITY OR TOWN <i>Salisbury, Wicomico, Maryland</i> | | | COUNTY | | STATE |
| 24. FUNERAL DIRECTOR NAME <i>HOLLOWAY & CO., SALISBURY, MD.</i> | | | 25a. DATE REC'D. BY REGISTRAR <i>AUG 15 1979</i> | | | 25b. REGISTRAR'S SIGNATURE <i>Henry McCloudy</i> | | | | | | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

9 2 1 1 0 8

FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|---|---|---|--|--------------------------------------|---------------------|--|-------------|-----------------------------------|------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | |
| Julia A. Parsons | | | | | | August 7 1979 | | | | 7 40 AM | |
| 3. SEX | | 4. RACE | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | 7b. HOUR | |
| Female | | White | Month | Day | Year | 77 | | | | 7 40 AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Delaware | | U. S. A. | | | | Wicomico | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Salisbury | | Peninsula General Hospital | | | Housewife | | | | | --- | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS | | | | |
| Delaware | | Sussex | Delmar | | | | Route #2 | | | | |
| 14. FATHER'S NAME | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | | MIDDLE | | | LAST |
| Hermus Lowe | | | | | Rosa Lowe | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | |
| No | | 221-32-2065 | | | Alvin D. Parsons | | | Delmar, Del. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN'S</u> 410- Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last | | | | | | | | | | | |
| { DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC CARDIO -</u> IN OFF. DUE TO, OR AS A CONSEQUENCE OF (c) <u>VASCULAR DISEASE</u> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>NEPHROLETHIASIS</u> RIGHT | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| No | | | | | <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>8-1 1979</u> to <u>8-7 1979</u> , that (I) (we) last saw the deceased alive on <u>8-7 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d. DATE SIGNED | | | |
| <u>John M. Bloxom Jr.</u> | | | | | | | | <u>8-7-1979</u> | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22f. ADDRESS | | | | | | | | | |
| <u>JOHN M. BLOXOM JR.</u> | | <u>MEDICAL CENTER, SALISBURY, MD</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION CITY OR TOWN | | | 23e. COUNTY | 23f. STATE | |
| Burial | | 8-10-79 | St. Stephens | | | Delmar, Sussex | | | Del. | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| <u>William M. Short Jr.</u> | | <u>Delmar, Del. 19940</u> | | | | | | <u>Henry McBrady</u> | | | |
| BP _____ | | | | | AUG 13 1979 | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 must be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ATC00000

Continuing general discussion

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use in the funeral-parlour papers. Then phone remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical certifying physician must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 21109 | | | | |
|--|--|--|--|---|--|--|---|--|--|--|--|---|--------------|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | MIDDLE | | | LAST | | | 2d. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | | |
| WILLIAM GREENSBERRY | | | | | | | PASSWATERS | | | AUGUST 14, 1979 | | | 120 M | | | |
| 1. SEX | | 4 RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | | | |
| MALE | | CALS. | | JAN 6 1914 | | | 65 | | | | | | | | | |
| 7a. BIRTHPLACE (STATES OR FOREIGN COUNTRY) DELAWARE | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | | MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARM OWNER | | | 12b. KIND OF BUSINESS OR INDUSTRY FARMING | | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | |
| 13a. STATE DELAWARE | | 13b. COUNTY SUSSEX | | 13c. CITY OR TOWN BRIDGEVILLE | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS RD #2 BOX 22A - REDDEN ROAD | | | | | | |
| 14. FATHER'S NAME FIRST William | | MIDDLE HENRY | | LAST PASSWATERS | | | 15. MOTHER'S MAIDEN NAME FIRST GOLDEN MAE WILLIAMSON | | | LAST PASSWATERS | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. - | | 17. INFORMANT 221-10-8339 | | | ADDRESS MARIE ALLEN PASSWATERS BRIDGEVILLE, De. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5m | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio pulmonary arrest 20 | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4341 (b) consecutive cerebral infarction | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) consecutive cerebral infarction | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) subacute alcohol hepatitis | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER: NOTIFY MEDICAL EXAMINER) None | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) None | | | | | | | | | | | | |
| 21d. INJURY OCCURRED None | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) None | | 21f. LOCATION STREET None | | | CITY OR TOWN None | | | COUNTY None | | STATE None | | | | |
| 22a. I certify that (I) (we) attended the deceased from 8-1 1979 to 8-14 1979 , that (I) (we) last saw the deceased alive on 8-14 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE James W. Spence, MD | | | | | | | | | | 22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) James W. Spence, MD | | 22e. ADDRESS 3 Medical Center, Salisbury, Md. | | | | | | | | | | 22f. DATE SIGNED 8/16/79 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | 23b. DATE AUG. 17, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY 1000 FELLOWS CEMETERY, SEAFORD SUSSEX DELAWARE | | | 23d. LOCATION CITY OR TOWN SEAFORD SUSSEX DELAWARE | | | COUNTY SUSSEX | | STATE DELAWARE | | | | |
| 24. FUNERAL DIRECTOR NAME PAYNTER M. WATSON - SEAFORD, DEL - 19973 | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR AUG 23 1979 | | | 25b. REGISTRAR'S SIGNATURE Paynter M. Watson | | | | | | | | | |

23

поезд

23Г

один из самых быстрых в Европе - 150 км/ч

самый быстрый поезд в Европе - 250 км/ч

один из самых быстрых в Европе - 250 км/ч

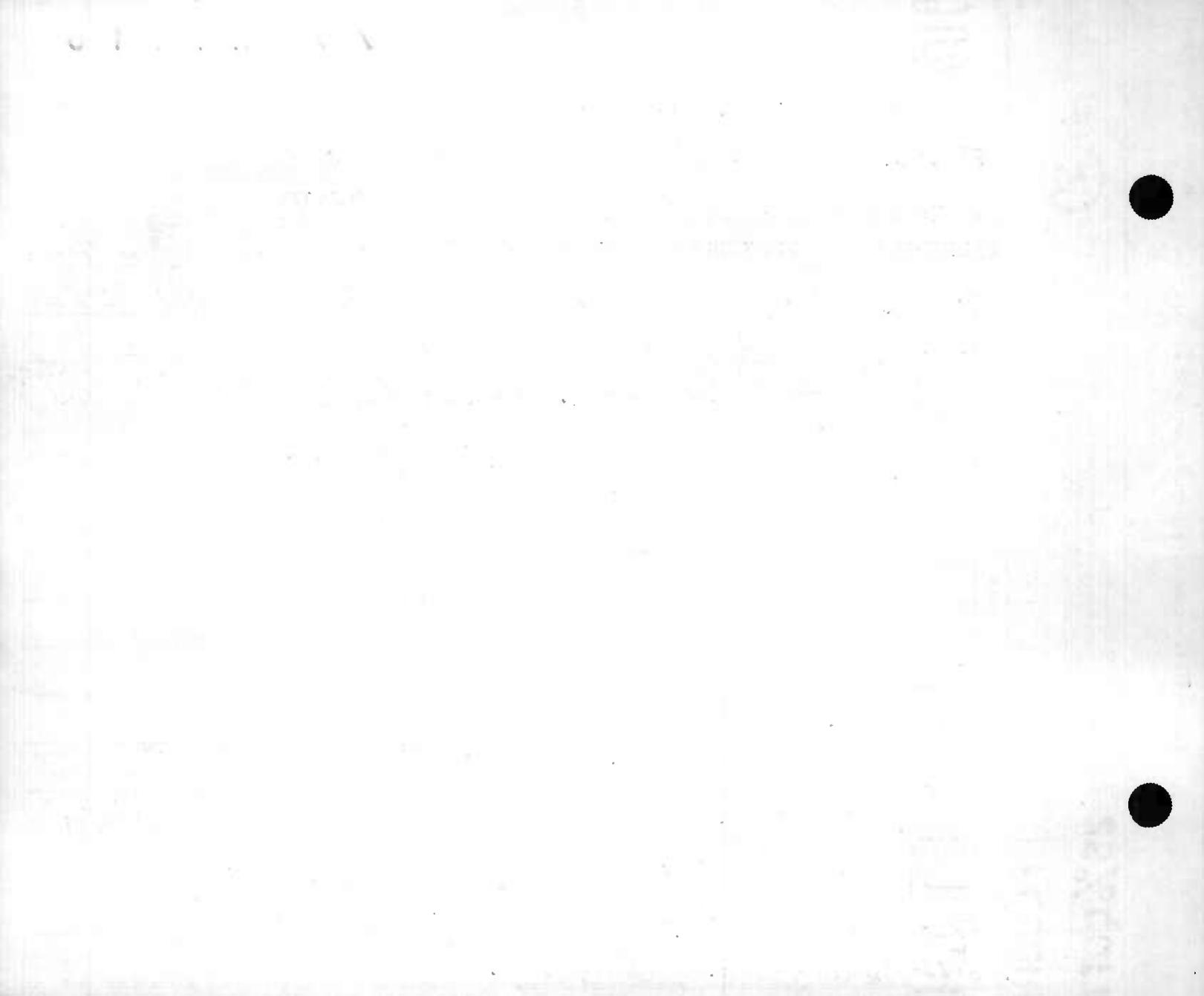
один из самых быстрых в Европе - 250 км/ч

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 9 2 1 1 1 0 | |
|---|--|---|--|--|--------|---|----------------------------------|---------------|--|--|-----------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | | |
| <i>MARIAN MAY Peterman</i> | | | | | | | August 16 1979 | | | | 4 50 P.M. | | |
| 3. SEX | | 4 RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | | 7 IF UNDER 1 YEAR | | | |
| <i>FEMALE</i> | | <i>WHITE</i> | | <i>2-12-1897</i> | | <i>82</i> | | | | MONTHS DAYS HOURS MIN | | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7c. CITIZEN OF WHAT COUNTRY? | | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | MD. | | | |
| <i>Maryland</i> | | <i>U.S.A.</i> | | | | <i>WICOMICO</i> | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| <i>SALISBURY</i> | | <i>PENINSULA GENERAL HOSPITAL</i> | | | | | | | | | | <i>Housewife - Civil Home</i> | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET ADDRESS | | | |
| <i>Maryland</i> | | <i>Wicomico</i> | | <i>Hebron</i> | | | | | | <i>Potermill Rd - 21830</i> | | | |
| 14. FATHER'S NAME FIRST | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME FIRST | | | | LAST | | | |
| <i>Henry</i> | | <i>Rock</i> | | <i>Eva</i> | | | | | | <i>Jones</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | ADDRESS | | | |
| <i>No</i> | | | | <i>220-26-3364</i> | | <i>Agnes White</i> | | | | <i>305 Robin Ave Salisbury, Md.</i> | | | |
| 18 CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>CVA with right paralysis</i> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF { (b) <i>436-</i> DUE TO, OR AS A CONSEQUENCE OF (c) } | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | | |
| 22a. I certify that (I) (he/she) attended the deceased from <i>8/16</i> , 19 <i>79</i> , to <i>8/16</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>8/16</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>W. Ben Horner MD</i> DEGREE | | | | | | | | | | | | 22c. DATE SIGNED <i>8/16/79</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | | |
| <i>W. Ben Horner M.D.</i> | | <i>Kay Avenue Salisbury Md.</i> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE <i>8-19-1979</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Springhill Memorial Cemetery</i> | | 23d. LOCATION CITY OR TOWN <i>Hebron, Md.</i> | | COUNTY | | STATE | | | |
| 24. FUNERAL DIRECTOR NAME <i>Hill-Broker-Bounds</i> | | ADDRESS <i>Salisbury, Md.</i> | | 25a. DATE REC'D. BY REGISTRAR <i>AUG 21 1979</i> | | 25b. REGISTRAR'S SIGNATURE <i>Notary Public</i> | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be dated for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | | | | | | | | |
|--|--|--|--|---|--------|---|---|---|--|----------------|--|--|----------|--|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH | | | | | | 2b. HOUR | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | | | | | | | |
| <i>James Osbury</i> | | | | | | <i>Phoebus</i> | <i>August 5, 1979</i> | | | <i>9:30 PM</i> | | | | | | | | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH JUNE 1, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS | | | | | | | | |
| | | | | | | 70 | | | MONTHS | | | DAYS | | | | | | | | |
| 7a. BIRTHPLACE MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO | | | 10. CITY OR TOWN OF DEATH Salisbury | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PENINSULA General Hospital | | | | | | | | |
| 12a. USUAL OCCUPATION RETIRED | | | 12b. KIND OF BUSINESS OR INDUSTRY MD | | | 13a. STATE MD. | | | 13b. COUNTY WICOMICO | | | 13c. CITY OR TOWN SALISBURY | | | | | | | | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 720 EDGAR DR. | | | 14. FATHER'S NAME JAMES PHOEBUS | | | 15. MOTHER'S MAIDEN NAME LAURA HEATH | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 220-01-7210 | | | 17. INFORMANT MRS FLORENCE PHOEBUS SAME AS 13 | | |
| 18. CAUSE OF DEATH Enter only one cause per line for 1a., 1b., and 1c. PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral vascular accident</i> | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 4340 Conditions, if any, which gave rise to immediate cause 1a., stating the underlying cause last (b) <i>Advanced cerebral arteriosclerosis</i> (c) <i>of cerebral thrombosis & diabetes mellitus</i> | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <i>Arterio sclerotic heart disease</i> | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY STATE | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/30/79 to 8/15/79 , that (I) (we) last saw the deceased alive on 8/15/79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | | | | | 22c. DATE SIGNED 8/7/79 | | | | | |
| 22b. SIGNATURE <i>J. S. Sander, M.D.</i> | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph S. Sander, M.D. | | | | | | 22e. DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 8/8/79 | | 23c. NAME OF CEMETERY OR CREMATORIAL SILOAM CEMETERY | | | 23d. LOCATION CITY OR TOWN SILOAM, MD. | | | COUNTY STATE | | | | | | | | | | |
| 24. FUNERAL DIRECTOR LEVIN R. WILSON SALISBURY, MD. | | 25a. DATE REC'D. BY REGISTRAR AUG 13 1979 | | | | | | 25b. REGISTRAR'S SIGNATURE <i>Levin R. Wilson</i> | | | | | | | | | | | | |

16 CONYC

Estoppel clause blocking transfer?

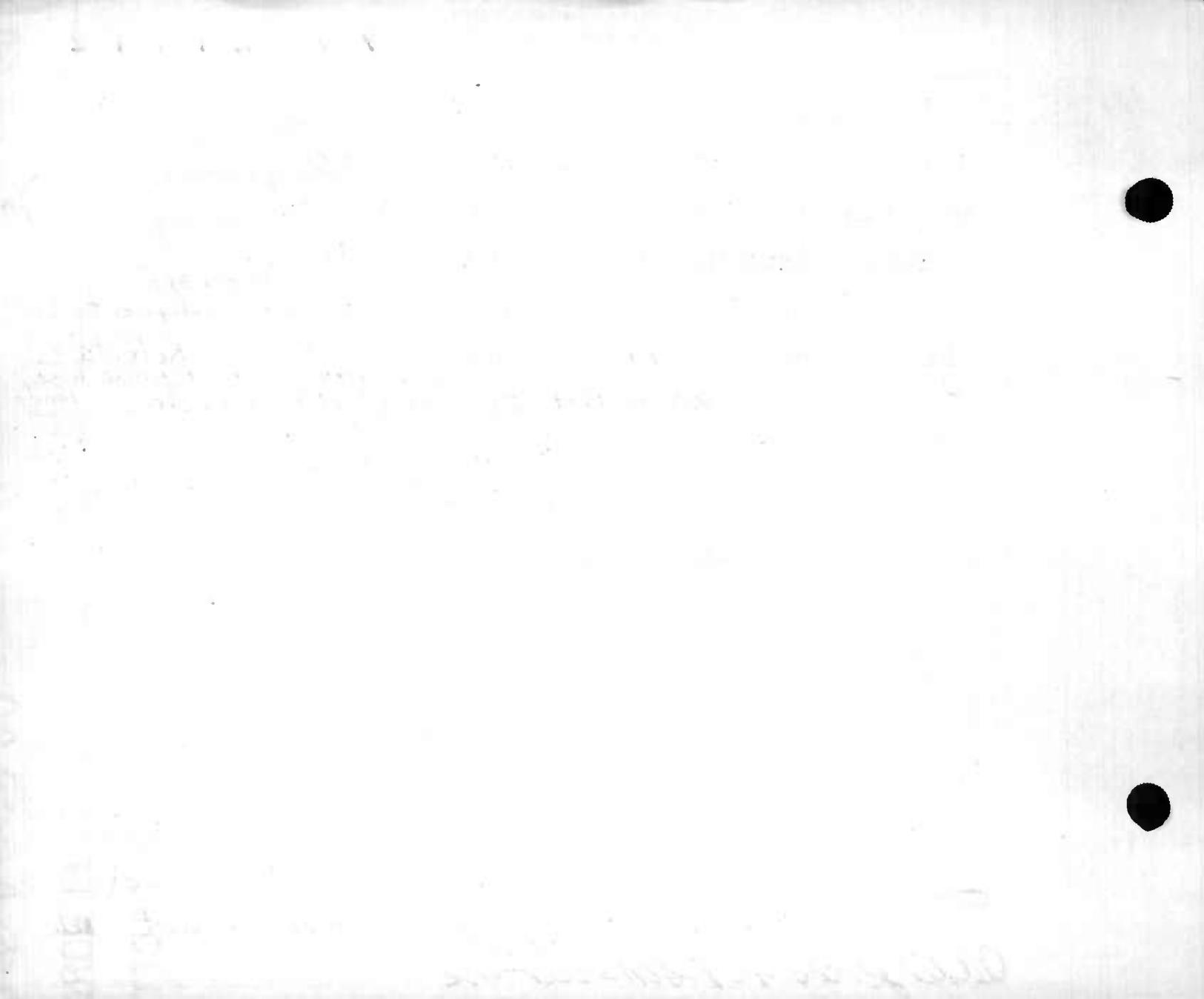
Perch, et al.
10/13/1987 - 10/13/1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 9 2 1 1 1 2 | |
|--|--|--|---|--|--|---|--|--|---|----------------------|--|
| 1 - STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR 8-21-79 | | | | | | | 2b. HOUR 1:30 P.M. | |
| 1 DECEASED NAME FIRST SEDORIA CARR MIDDLE PLUMMER LAST | | | 5. DATE OF BIRTH MONTH 6 DAY 15 YEAR 29 | | | 6 AGE (IN YEARS LAST BIRTHDAY) 50 YRS. | | | 7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN | | |
| 3. SEX Female RACE Black | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD. | | |
| 10. CITY OR TOWN OF DEATH SALISBURY | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PENINSULA GENERAL HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md. 13b. COUNTY Somerset 13c. CITY OR TOWN Princess Anne | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS P.O. Box 303 Fair Haven Development | | | | | |
| 14. FATHER'S NAME FIRST Leon MIDDLE H. LAST Carr | | | 15. MOTHER'S MAIDEN NAME FIRST Theresa M. LAST Roberts | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. 213-22-4794 | | | 17. INFORMANT Salisbury Md. ADDRESS P.O. Box 1330 Jersey Lane | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (1a) <u>Cerebral Hemorrhage</u> 2502 Conditions, if any, which gave rise to immediate cause (1a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension Non-Ketotic Diabetic Coma</u> 4 days. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u> . 2 months. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 8-14-79 to 8-21-79, that (we) lost now the deceased alive on 8-21-79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE ROGER C. MERRILL | | | 22c. DEGREE M.D. | | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22e. DATE SIGNED 8-21-79 | | |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT) ROGER C. MERRILL | | | 22g. ADDRESS KAY AVE. SALISBURY, MD | | | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE 8/25/79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL JOHN WESLEY | | | 23d. LOCATION CITY OR TOWN PR. HANE SOMERSET MD. | | |
| 24. FUNERAL DIRECTOR NAME ADDIE JAMES 407 SOMERSET AVE | | | 25a. ADDRESS P.O. BOX 1330 | | | 25b. DATE REC'D. BY REGISTRAR AUG 27 1979 | | | 25c. REGISTRAR'S SIGNATURE MARY McBRADY | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--------|--------------------------------------|---------------------------|---|---|--|--|--|----------------------------------|---|---|---|--------------------------------------|--|---|--|--------------------------------|--|------------------------------|--|---|--|--|--|--|--|--|--|-----------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2. DATE OF DEATH MONTH DAY YEAR | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | FIRST | MIDDLE | LAST | | 3. SEX | | | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | | | | | | | | | | | | |
| BERTHA M. Robinson | | | | | | Robinson | | Female | | | | White | | 8-14-17 | | | 62 yrs | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 | | MARRIED <input checked="" type="checkbox"/> | | NEVER MARRIED <input type="checkbox"/> | | WIDOWED <input type="checkbox"/> | | DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| N.J. | | | | USA | | | 8 | | <input checked="" type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | | Wicomico | | | | Salisbury | | | | Peninsula General Hospital | | | | OPERATOR | | | | GARMENT | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS | | | | 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | | | | | | | | |
| MD. | | | | WIC | | SARPTON | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 100 CHURCH ST. | | | | PHILIP MYERS | | | | BERTHA MYERS | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | 16c. INFORMANT ADDRESS | | | | 17. INFORMANT ADDRESS | | | | 18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | |
| NO | | | | 151-Q-9034 | | | CHARLES ROBINSON | | | | SARPTON | | | | | | | | lung Cancer | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | | | |
| 9/9 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET | | | | CITY OR TOWN | | | | COUNTY | | | | STATE | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/8/79 , 19 79 , to 8/4/79 , 19 79 , that (I) (we) last saw the deceased alive on 8/4/79 , 19 79 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) (we) did <input checked="" type="checkbox"/> did not <input type="checkbox"/> view the body after death. | | | | | | | | | | | | 22b. SIGNATURE Joseph A. Grasso DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Grasso | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIAL | | 23d. LOCATION CITY OR TOWN | | | | 23e. COUNTY | | | | 23f. STATE | | | | | | | | | | | | | | | | | | | | |
| BURIAL | | | | 8-7-79 | | FIREMAN'S CEM. | | SARPTON, WIC, MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ULRICH FULTON | | | | ADDRESS SAFETY HOME SAAPTOWN, MS. | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE Ulrich Fulton | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Navigation

Navigation: Geodesy (Geodetic)

Navigation

Items #18a-22a Film G535 9/26/79 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

9 2 1 1 1 4

1-
FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

2a DATE KNOWN

MONTH

DAY

YEAR

2b HOUR

Susan Elsbeth

Robinson

8

27

19

79

M

3. SEX

4 RACE

5 DATE OF BIRTH
MONTH DAY YEAR6 AGE (IN YEARS
(LAST BIRTHDAY)7 IF UNDER 1 YR.
MONTHS DAYS8 IF UNDER 24 HRS.
HOURS MIN2c DATE ESTI-
DEATH MATED

MONTH

DAY

YEAR

2d HOUR
24 HOUR

female

white

9- 121942 36 yrs.

7a BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

7b CITIZEN OF WHAT COUNTRY?

8 MARRIED NEVER MARRIED
WIDOWED DIVORCED

9 BALTIMORE CITY OR COUNTY OF DEATH

MONTH

DAY

YEAR

12a DATE PRONOUNCED
DEAD

8

27

19

79

12:53

a

m

10. CITY OR TOWN OF DEATH

Salisbury

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Peninsula General Hosp. (DOA)

12a USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

Employee (Sales)

12b KIND OF BUSINESS
OR INDUSTRY

Central Suppl

ly

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

14. FATHER'S NAME

FIRST

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

(IF YES, GIVE WAR OR DATES)

No

16b. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Salisbury, Md.

E. Main St.

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

Undetermined

7999

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES NO

21a. EXTERNAL CAUSE WAS

UNDERLYING OR
CONTRIBUTING CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR

P.M.

19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE NOT WHILE
AT WORK AT WORK 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an

Autopsy Inspection Inquiry

and in my opinion

death resulted from:

Natural causes Accident Suicide Homicide Undetermined manner ACTUAL
SIGNATURE

Virginia L. Dolan

M.D.

TITLE (SPECIFY)
Assistant MEDICAL EXAMINERDATE
SIGNED

8-28-79

EXAMINER'S NAME
(TYPE OR PRINT)

Virginia L. Dolan, M.D.

ADDRESS

111 Penn St.

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION
CITY OR TOWN

COUNTY

STATE

Burial

8-31-1979

Greenlawn Cemetery

Lansdale

Pa.

24. FUNERAL DIRECTOR
NAME

ADDRESS

Holloway Funeral Home P.A. Salisbury,

25a. DATE REC'D. BY REGISTRAR

Md AUG 29 1979

25b. REGISTRAR'S SIGNATURE

Patsy McCreedy

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NEEDED, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR FUNERAL DIRECTOR: PAGE 5 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT, WITH AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME(5))
1SM 7/76

200 C. C. L.

• C. L. I.

D. C. L.

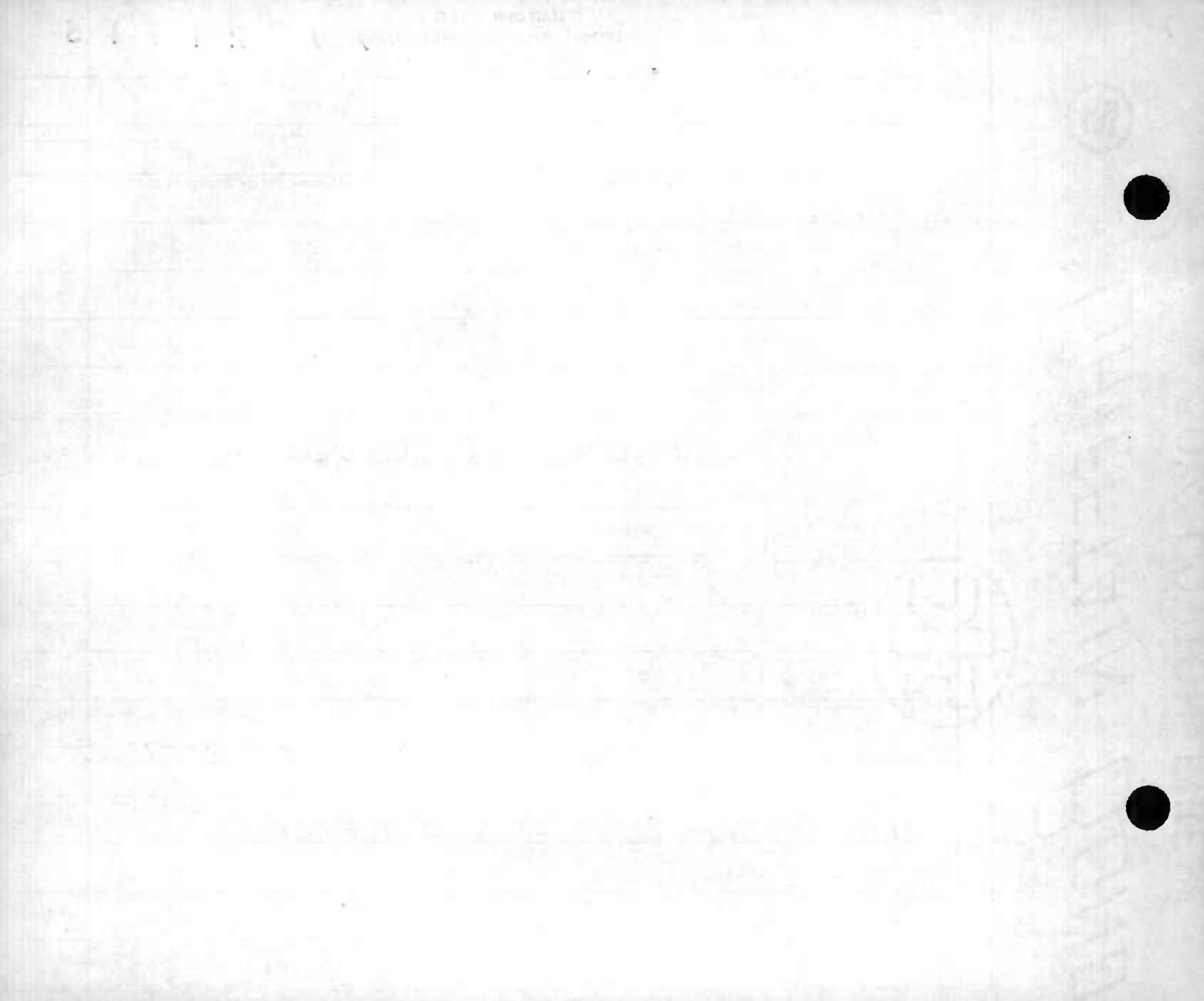
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, if retron by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to a burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

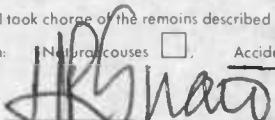
MEDICAL CERTIFICATION

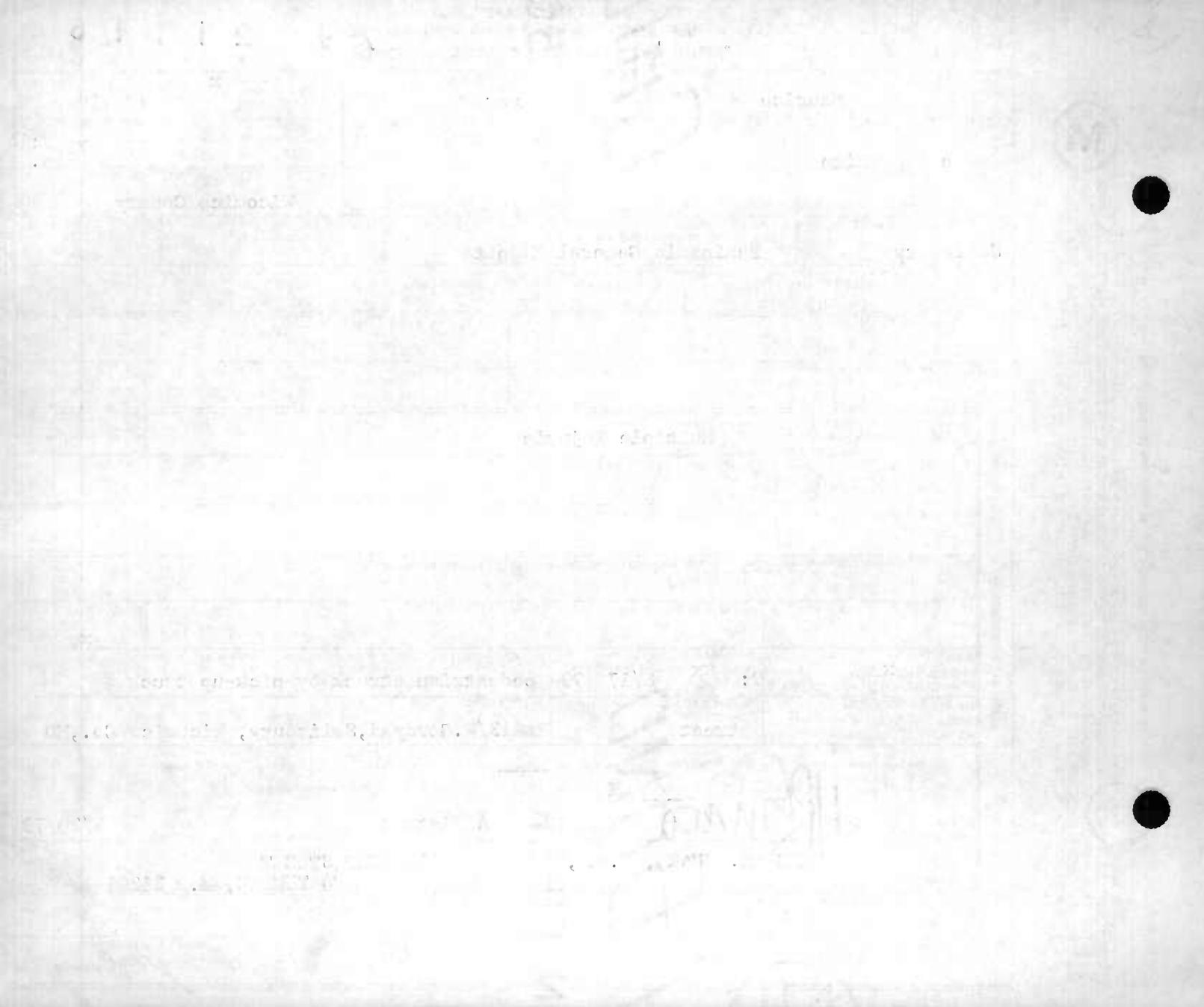
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 9 2 1 1 1 5 | | | |
|--|--|--|---|--------|------|---|--|--|--|--|---|--|-----------------------------|-------------------------------|---------|
| 1 - FOR STATE REGISTRAR | | | CHARLES PARKER | | | ROUNDS | | | 2a DATE OF DEATH | | | MONTH | DAY | YEAR | 2b HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | | | | August 8, 1979 | | | | | | |
| 3 SEX Male | | | 4 RACE White | | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 7, 1911 | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Snow Hill, Md. | | | 7b CITIZEN OF WHAT COUNTRY? USA | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH WICOMICO | | | MD. | | | |
| 10 CITY OR TOWN OF DEATH Salisbury | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 201 Priscilla Street | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician | | | 12b. KIND OF BUSINESS OR INDUSTRY Public Service | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Wicomico | | | 13c. CITY OR TOWN Salisbury | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 201 Priscilla Street | | | |
| 14 FATHER'S NAME FIRST Harry | | | MIDDLE Rounds | | | 15. MOTHER'S MAIDEN NAME FIRST Lottie | | | R. MIDDLE | | | LAST Sharpley | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b SOCIAL SECURITY NO. 214-10-7994 | | | 17. INFORMANT Mrs. Marie C. Rounds (wife) same as 13 | | | ADDRESS | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteries broke C - Volved</i> DUE TO, OR AS A CONSEQUENCE OF <i>4292</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | COUNTY | | STATE | | |
| 22a I certify that (I) (this hospital) attended the deceased from <i>8-8-79</i> , to <i>8-8-79</i> , that (I) (we) last saw the deceased alive on <i>8-8-79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Wilber R. Ellis</i> | | | 22c. DEGREE <i>M.D.</i> | | | ATTENDING PHYSICIAN <input type="checkbox"/> | | | MEDICAL DIRECTOR <input type="checkbox"/> | | STAFF PHYSICIAN <input type="checkbox"/> | | 22d. DATE SIGNED 8/10/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wilber R. Ellis, M.D. | | | 22e. ADDRESS Salisbury, Maryland | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 8/11/79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park | | | 23d. LOCATION CITY OR TOWN Salisbury, Wicomico, Md. | | | COUNTY | | STATE | |
| 24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Maryland | | | ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR AUG 13 1979 | | | 25b. REGISTRAR'S SIGNATURE <i>Holloway McCreary</i> | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 8. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3, RETAIN PAGE 5 FOR YOUR RECORDS.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 21116 | | | | | | | |
|--|--|--|---|--|--|--|--|------------------------------------|---|-------------------------------|--|---|--|--------------------------------------|--|------------|-----------------------------------|-----------|--------------------|
| 1- STATE REGISTRAR | | | FIRST | | | MIDDLE | | | LAST | | | 2a. DATE KNOWN OF ESTI- DEATH MATED | | MONTH 8 | DAY 17 | YEAR 1979 | 2b. HOUR 9:14 p.m. | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | Maurice | | | --- | | | Ruark | | | <input checked="" type="checkbox"/> | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 2c. DATE PRONOUNCED DEAD | | MONTH 8 | DAY 17 | YEAR 1979 | 2d. HOUR 9:14 p.m. |
| male | | | white | | | May 12, 1917 | | 62 yrs. | | | | | | <input type="checkbox"/> | | | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? | | | USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| 10. CITY OR TOWN OF DEATH | | | Salisbury | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | Peninsula General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | Floor Finisher | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | Salisbury | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | Cherry Way | | | |
| Maryland | | | Wicomico | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| Walter Berry Ruark | | | | | | Delia | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | | | | ADDRESS | | | | | | | |
| Yes WW II | | | | | | (brother) | | | | | | Mr. Grover H. Ruark, Salisbury, Md. | | 809 E. William St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Multiple Injuries | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| IMMEDIATE CAUSE (a) 8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR 9:00 AM 8/17 1979 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | pedestrian struck by pick-up truck | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street | | | 21f. LOCATION | | | STREET Rt#13/W.Gordy Rd, Salisbury, Wicomico Co., MD | | | CITY OR TOWN | | COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER | | | | |
| ACTUAL SIGNATURE  | | | | | | | | | | | | | | | DATE SIGNED 8/20/79 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | HORMEZ R. GUARD, M.D., | | | ADDRESS | | | 111 PENN STREET BALTIMORE, M.D. 21201 | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIUM | | | 23d. LOCATION CITY OR TOWN R.D. | | | COUNTY | | STATE | | | | | |
| Burial | | | 8/22/79 | | | Smullen Cemetery | | | | | | Worcester, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR | | | HOLLOWAY FUNERAL HOME, Salisbury, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| | | | | | | | | | AUG 23 1979 | | |  | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 9 2 1 1 1 7 | | |
|---|--|---|------------------------------------|--|--|-------------------|--|---|---------------------------------|--|--|---|--|--|
| 1 - FOR STATE REGISTRAR | | | 1 DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a DATE OF DEATH MONTH DAY YEAR | | | 2b HOUR | | |
| ANTHONY F. Russo | | | | | | | | | August 6 1979 | | | 8:30 A.M. | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6 AGE IN YEARS (LAST BIRTHDAY) | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | | | |
| MALE | | WHITE | | SEPT 2, 1896 | | | 82 | | | IF UNDER 24 HRS MONTHS DAYS HOURS MIN | | | | |
| 7a. BIRTHPLACE (COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | | |
| NEW YORK | | U.S.A. | | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | Wicomico | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Salisbury | | Peninsula General Hospital | | | PRINTER | | | G.P.O. | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | |
| 13a STATE | | 13b COUNTY | | 13c CITY OR TOWN | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e STREET ADDRESS | | | | |
| | | | | WASHINGTON, DC | | | | | | 4545 CONNECTICUT AVE., N.W. | | | | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | | | | |
| FRANCIS NICHOLAS | | FIRST MIDDLE LAST | | | FLORENCE W. RUSSO SAME AS 13 WIFE | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YEAR UNKNOWN) YES WW I 16b. SOCIAL SECURITY NO. 059-09-0254 17 INFORMANT | | | | | | | | | | | | ADDRESS | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 410- Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) And myocard. infarct | | | | | | | | | | | | See | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | See | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 01/01/79 to 01/02/79, that (I) (we) last saw the deceased alive on 01/01/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | 22c. DATE SIGNED 8/6/79 | | |
| 22b. SIGNATURE <i>John G Green</i> | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE 8/9/79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL GATE OF HEAVEN | | | 23d. LOCATION CITY OR TOWN SILVER SPRING COUNTY MONT STATE MD. | | | | | | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | | 25a. DATE REC'D. BY REGISTRAR AUG 08 1979 | | | 25b. REGISTRAR'S SIGNATURE <i>Patricia Hebrandy</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 7921118 | | | | |
|--|--|--|---|--|--|--|--|--|---|--|--|---|--|--|-----------------------------------|--|
| 1 - FOR STATE REGISTRAR | | | 2a DATE OF DEATH MONTH DAY YEAR | | | | | | | | | 2b HOUR | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE | | | LAST | | | 2a DATE OF DEATH MONTH DAY YEAR | | | 2b HOUR | | | | |
| Ruth A. Rutherford | | | | | | | | | August 2, 1979 | | | 3 52 M | | | | |
| 3 SEX | | | 4 RACE | | | 5 DATE OF BIRTH MONTH DAY YEAR | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | 7b UNDER 1 YEAR | | | | |
| Female | | | White | | | 7-5-1907 | | | 72 | | | MONTHS DAYS HOURS MIN | | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | YRS | | | | |
| N.Y. | | | U.S. | | | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | Wicomico | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Salisbury | | | Peninsula General Hospital | | | | | | | | | Housewife | | | Own Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS | | | | |
| MF | | | Wicomico | | | Bivalve | | | | | | | | | | |
| 14 FATHER'S NAME | | | MIDDLE | | | LAST | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Edward | | | White | | | | | | Margaret | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b SOCIAL SECURITY NO. | | | 17 INFORMANT | | | ADDRESS | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| No | | | — | | | — | | | Joseph A. Rutherford, Bivalve, Md. | | | 6 days | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiac + renal failure | | | | | | | | | | | | | | | | |
| 4414 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Status post-operative resection DUE TO, OR AS A CONSEQUENCE OF abd. aortic aneurysm - (c) | | | | | | | | | | | | | | | | |
| 7 days | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Obstructive pulmonary disease | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION 7/26/79 | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED as above | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 7/25, 1979, to 9/2, 1979, that (I) (we) last saw the deceased alive on 8/1, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | COUNTY | | | | | | | |
| 22b. SIGNATURE William P. Sadler MD | | | 22c. DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | STATE | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) William P. Sadler MD | | | 22e. ADDRESS 521156cty, Md. | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 8/6/79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL St Charles Cemetery, Farmington, NY | | | 23d. LOCATION CITY OR TOWN | | | | | | | |
| 24 FUNERAL DIRECTOR NAME C. J. Messin Bivalve, Md. | | | 24b. BUSINESS 2514 | | | 25e. DATE REC'D. BY REGISTRAR AUG 8 1979 | | | 25d. REGISTRAR'S SIGNATURE Mary McAlady | | | | | | | |



177000000

Festina lente. Encyclopaedia Britannica

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed and advised.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | 9 | 2 | 1 | 1 | 9 | | |
|--|---|--|------------------|--|--|---|--|---|-----------------------------------|---|-----------------|--|-------------------|---|---|---|---|--|
| | | | | | | | | | | | | REG. NO. | | | | | | |
| 1 - FOR STATE REGISTRAR | 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | | | | | |
| | Ivatury Gowri Sankaran | | | | | | August 28 | | | 1979 | | | 6 ⁰² M | | | | | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | | | |
| Male | W | | MONTH | 2 | DAY | 21 | YEAR | 57 | MONTHS | DAYS | HOURS | MIN | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | | 8 | | | MARRIED <input checked="" type="checkbox"/> | NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> | DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | |
| A.P. India | U.S.A. | | | | | | | | | Wicomico | | | | | | | | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | Peninsula General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| Salisbury | | | | | | | Teacher | | | U.M.E.S. Coll | | | | | | | | |
| 13a. STATE Maryland | | | | | | | | | | | | 13c. CITY OR TOWN Somerset Princess Anne | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS B06 S. College Place | |
| 14. FATHER'S NAME FIRST Ivatury MIDDLE Nagabhushanarao LAST | | | | | | | | | | | | 15. MOTHER'S MAIDEN NAME XXX FIRST Ivatury MIDDLE Venkayamma LAST | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | ADDRESS | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| No | | 017-28-4810 | | Anasuya I. Sankaran | | | | | | MINS | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line of 18, 1b, 1c, 1d, 1e, 1f) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (1a) | | | | | | | | | | | | (1b) Cardio-pulmonary Arrest | | | | | | |
| 4149 Conditions, if any, which gave rise to immediate cause (1a), stating the underlying cause (1b) | | | | | | | | | | | | (1c) Hypertensive Heart Disease | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (1d) | | | | | | | | | | | | (1e) | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | COUNTY | STATE | | | | | | | | |
| 22a. I certify that (I) attended the deceased from 1977, 19, to 1978, 19, that (I) we lost saw the deceased alive on 8/28, 1978, and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) did not view the body after death. | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Donald M. Wood | | 22c. DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d. DATE SIGNED 8/29/79 | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald M. Wood | | 22e. ADDRESS 215 Ohio Ave Salisbury Maryland | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 8-30-1979 | | 23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory Lewes | | | 23d. LOCATION CITY OR TOWN | | COUNTY | STATE | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Holloway Funeral Home P.A. Salisbury, Md | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR SEP 4 1979 | | | 25b. REGISTRAR'S SIGNATURE Holloway | | | | | | | | | | |

MI

001 0027

Int'l legal Intercell shareholders
graduates

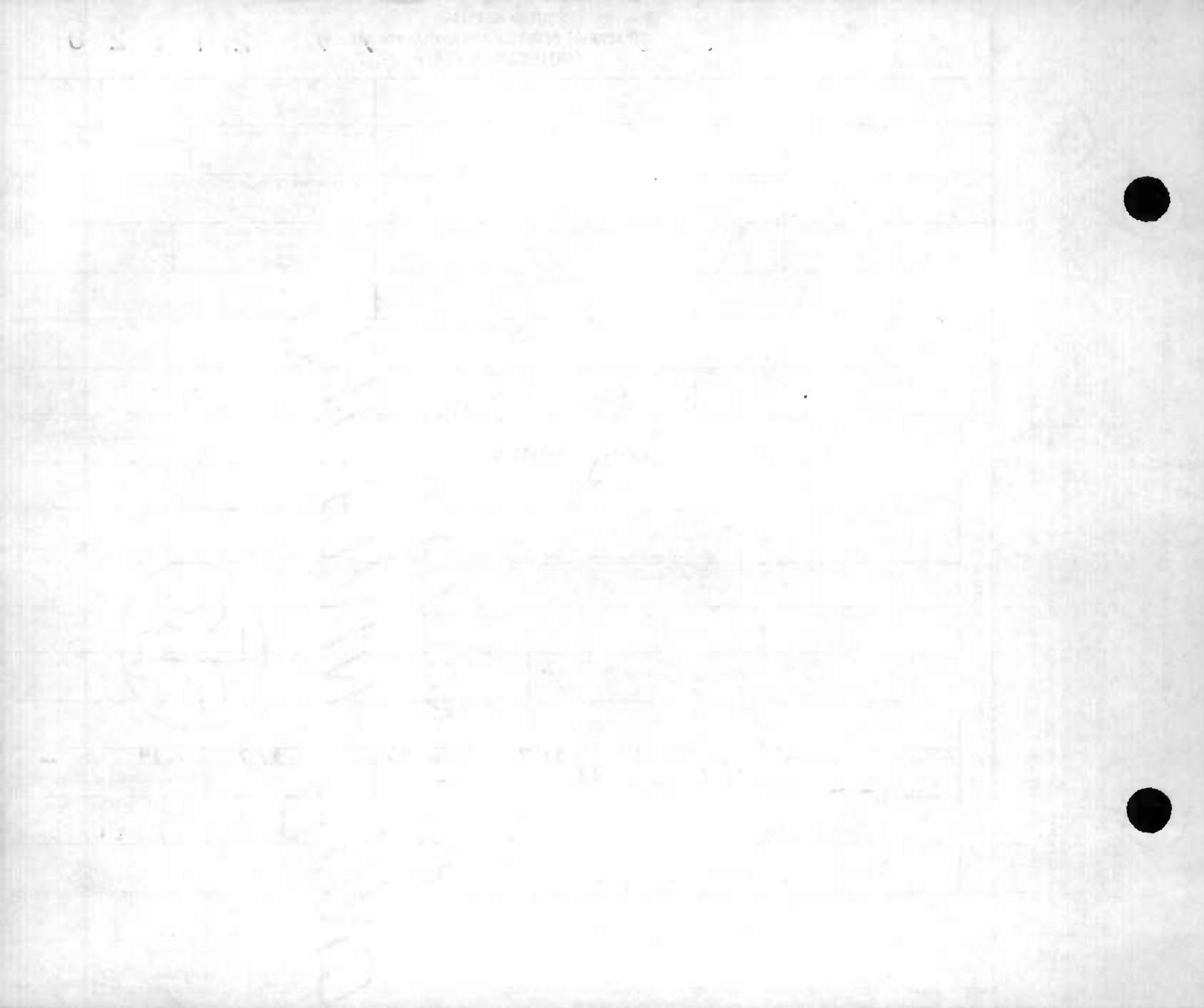
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | 9 | 2 | 1 | 1 | 2 | 0 |
|--|-------------------------------------|-------------------|--|------------------------------------|----------------------------------|---|---|-----------------------------------|---|--------------------------------|-----------------|--|----------|---|--------------------------------------|---|---|
| | | | | | | | | | | | | REG. NO. | | | | | |
| 1 - FOR STATE REGISTRAR | 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | | | | |
| | WALLACE | | | MILTON | | SCOTT | August 17, 1979 | | | | | | | | | | |
| 3. SEX | 4. RACE | | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | | | | |
| Male | White | | | March 16, 1920 | | | 59 | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 | MARRIED <input type="checkbox"/> | NEVER MARRIED <input type="checkbox"/> | WIDOWED <input checked="" type="checkbox"/> | DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | WICOMICO | | | | | |
| Willards, Md. | USA | | | | | | | | 10. CITY OR TOWN OF DEATH | | | Salisbury | | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | |
| 116 Marvel Road | | | | | | | | | | | | Contractor | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | 13a. STREET ADDRESS | | | Paving | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS | | | 116 Marvel Road | | | | | | | | |
| Maryland | Wicomico | Salisbury | | | | 14. FATHER'S NAME | | | Sarah | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST Arthur | MIDDLE M. | LAST Scott | | | | FIRST B. | | | MIDDLE | LAST | Sarah B. Powell | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| Yes | | | WW II | | | (daughter) Mrs. Susan S. Palmer, Delmar, Md. | | | Rt. 3, Box 37A | | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | | | | | | | lung Cancer | | | | | |
| 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | |
| | | | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | COUNTY | STATE | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 31/7 1979 to 8/7 1979, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did not) view the body after death. | | | | | | | | | | | | 22c. DATE SIGNED 8/21/79 | | | | | |
| 22b. SIGNATURE <i>Joseph A. Grasso</i> | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Grasso, M.D. | | | 22e. ADDRESS Salisbury, Maryland | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 8/20/79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park | | | 23d. LOCATION CITY OR TOWN Salisbury, Wic., Maryland | | | COUNTY | STATE | | | | |
| 24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Maryland | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR AUG 23 1979 | | | 25b. REGISTRAR'S SIGNATURE <i>Hector McBrady</i> | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

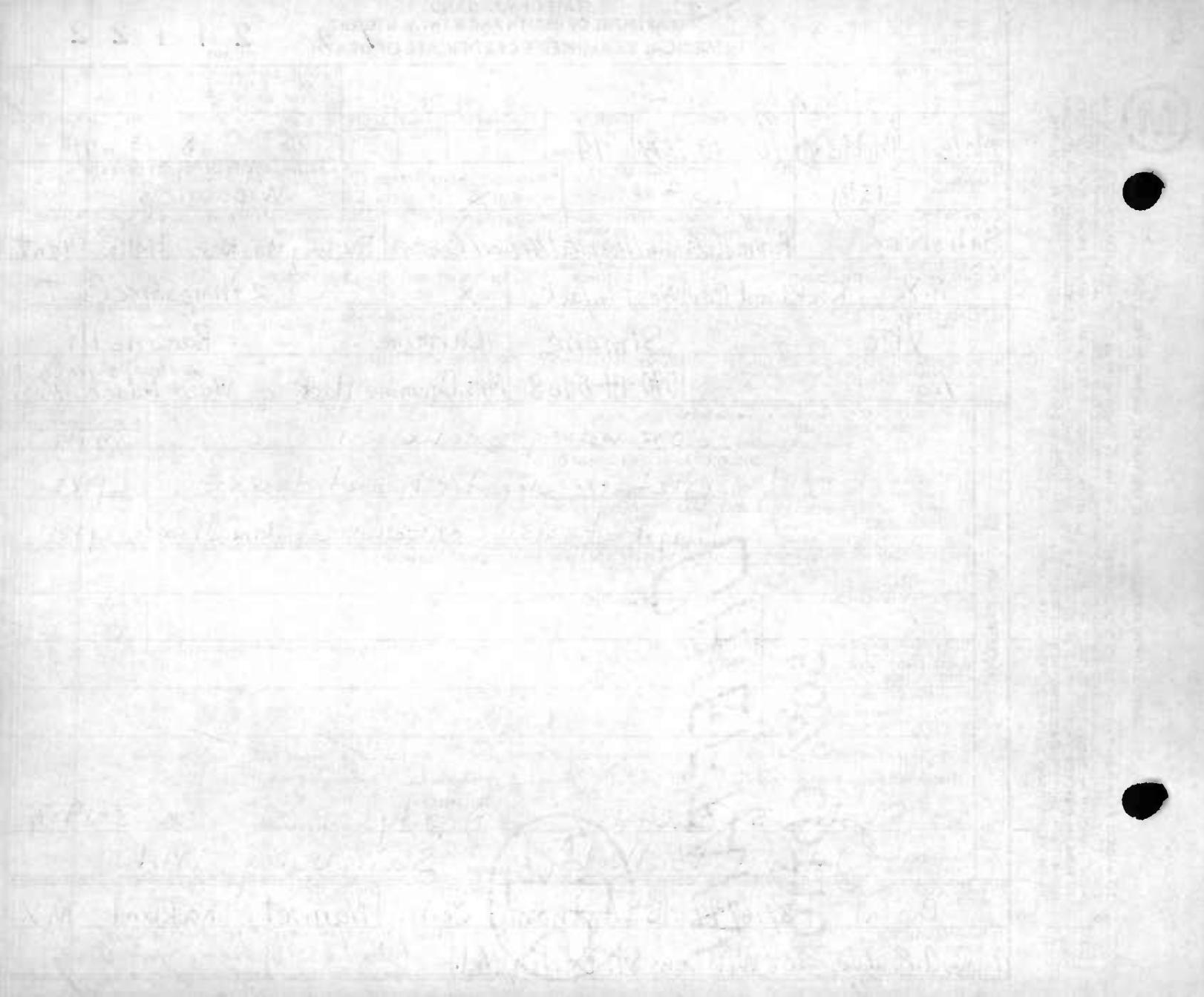
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. | |
|---|--|--|---|--|--|---|--|--|---|--|--|---|-------|
| 1 - FOR STATE REGISTRAR | | | 1a. DECEASED NAME (TYPE OR PRINT) | | | 1b. FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | |
| | | | VINTON DOWNES | | | Shufelt | | | August 8, 1979 | | | 11:35 P.M. | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS | | | IF UNDER 18 YEARS MONTHS DAYS HOURS MIN. | |
| Male | | | White | | | July 21, 1909 | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | |
| Federalsburg, Md. | | | USA | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Minister | | | 12b. KIND OF BUSINESS OR INDUSTRY Church | | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Wicomico | | | 13c. CITY OR TOWN Salisbury | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS Rt. 7, S. Kaywood Drive | |
| 14. FATHER'S NAME Elmer Friss | | | LAST | | | 15. MOTHER'S MAIDEN NAME Lura E. McMahan | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 217-12-4314 | | | 17. INFORMANT Mrs. Edith S. Shufelt (wife) | | | ADDRESS same as 13 | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| <p>18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c).</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <i>Hypocardiac infarction</i></p> <p>5334</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost</p> <p>(b) <i>Reactive septic ulcer</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c) <i>Reactive septic ulcer</i></p> | | | | | | | | | | | | | |
| <p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 8/7 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Reactive septic ulcer</i> | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY | STATE |
| <p>22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I)(we)(did) (did not) view the body after death.</p> <p>22b. SIGNATURE <i>Richard E. Hughes, M.D.</i></p> <p>DEGREE <i>M.D.</i></p> <p>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/></p> <p>22c. DATE SIGNED <i>8/8/79</i></p> | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard E. Hughes, M.D. | | | 22e. ADDRESS Salisbury, Md. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 8/12/79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Unity Washington Church Cem., Hurlock | | | 23d. LOCATION CITY OR TOWN | | | COUNTY | STATE |
| 24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, SALISBURY, Maryland | | | | | | | | | 25a. DATE RECEIVED BY REGISTRAR AUG 13 1979 | | | 25b. REGISTRAR'S SIGNATURE | |

Lasioglossum laevigatum Sundak 192

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | 21122 | |
|--|-----------|---|--|--|---------------------|--|------|---|---|--------|-----------|---|--|
| | | | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF ESTI- DEATH MATED | | | MONTH | DAY | YEAR | 2b. HOUR | |
| John | | | - | - | Simone | <input type="checkbox"/> | | | 19 | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | MONTHS | DAYS | HOURS | MIN | | | | |
| Male | Caucasian | 10 10 1899 | 79 yrs. | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | MONTH | DAY | YEAR | 2d. HOUR | |
| Italy | | U.S.A. | | | | | | | 8 | 13 | 1979 | M | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Salisbury | | | | Peninsula General Hospital/Medical Center | | | | Factory Worker | | | | Milk Plant | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS | |
| 13a. STATE N.Y. | | | | 13b. COUNTY Rockland Co. | | | | | | | | 2 Hampshire Court | |
| 14. FATHER'S NAME FIRST | | | | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | | | | MIDDLE | LAST | 16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Vito | | | | - | Simone | Carmine | | | | - | Racanelli | min | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. 090-14-5968 | | | | 17. INFORMANT Mrs. Carmine Hack | | | | ADDRESS 2 Hampshire Court West Nyack, N.Y. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) coronary occlusion | | | | | | | | | | | | | |
| 410- Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (b) arteriosclerotic heart disease | | | | | | | | | | | | 4 yrs | |
| { DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) hypertensive cardiovascular disease | | | | | | | | | | | | 4 yrs | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | 20. AUTOPSY? | |
| | | | | | | | | | | | | YES <input type="checkbox"/> | NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | COUNTY | STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion | | | | | | | | | | | | | |
| death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED 8-14-79 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | John T Bulkeley | | | | | | | | | | ADDRESS Salisbury, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE Burial 8/16/79 | | | 23c. NAME OF CEMETERY OR CREMATORIUM St. Anthony's Cem. | | | 23d. LOCATION Nanuet Rockland | | | COUNTY | STATE |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR AUG 17 1979 | | | 25b. REGISTRAR'S SIGNATURE John T Bulkeley | | | | |
| Anna A. Burdge | | | 108 Williams St. Berlin, Md. | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the certificate returned to the State Department of Health and Mental Hygiene.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. | |
|--|--|--|---|--|--|--|--|--|--|--------|--|---|-------|
| 1 - FOR STATE REGISTRAR | | | 2a DATE OF DEATH MONTH DAY YEAR | | | | | | | | | 2b HOUR | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | Aug 31 1979 5:49 P.M. | |
| Eleanor Leona Skiles | | | | | | | | | | | | | |
| 3 SEX Female | | | 4 RACE White | | | 5 DATE OF BIRTH MONTH DAY YEAR Nov. 6, 1922 | | | 6 AGE (IN YEARS LAST BIRTHDAY) 56 | | | IF UNDER 1 YEAR MONTHS DAYS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey | | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | | IF UNDER 24 HRS HOURS MIN | |
| 10 CITY OR TOWN OF DEATH Salisbury | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | 12b KIND OF BUSINESS OR INDUSTRY Self | | | | |
| 13a STATE Virginia | | | 13b COUNTY Accomack | | | 13c CITY OR TOWN Wallops Island | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e STREET ADDRESS 18 Wallops Road | |
| 14 FATHER'S NAME George Szwaranski | | | 15 MOTHER'S MAIDEN NAME Emily Milosh | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b SOCIAL SECURITY NO. 158-14-9042 | | | 17 INFORMANT James Skiles, Wallops Island, Virginia | | | ADDRESS | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 18 CAUSE OF DEATH (Enter only one cause per line for items (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lung Cancer</u> 1639 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) } DUE TO, OR AS A CONSEQUENCE OF (c) } DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | COUNTY | STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/23</u> , 19 <u>79</u> , to <u>8/31</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>8/31</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b SIGNATURE <u>Joseph A. Grasso, M.D.</u> | | | 22c. DEGREE <u>M.D.</u> | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d. DATE SIGNED <u>1300 S. Division St., Salisbury, Md.</u> | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b DATE 9-4-79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Rosedale Memorial Park | | | 23d. LOCATION CITY OR TOWN Linden, New Jersey | | | COUNTY | STATE |
| 24 FUNERAL DIRECTOR NAME Salyer Funeral Home, Chincoteague, Virginia | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR SEP 17 1979 | | | 25b. REGISTRAR'S SIGNATURE <u>Joseph A. Grasso</u> | | | | |
| BP _____ | | | | | | | | | | | | SEP 17 1979 | |

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Initial lateral orientation yards to

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be attached to the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If items 21 or 22 are marked or item 18 shows any injury, or other traumatic event, the medical examiner must be advised at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 21124 | | |
|---|--|--|---|---------------|---|--|--|--|--|----------------|--|--|
| 1. DECEASED NAME (PRINT OR PRINT) | | | FIRST | MIDDLE | LAST | 2a DATE OF DEATH MONTH DAY YEAR | | | 2b HOUR | | | |
| <u>R. S. SALEEE</u> | | | <u>L</u> | <u>Smiley</u> | <u>9 9 34</u> | <u>August 17 1979</u> | | | <u>6 30 M</u> | | | |
| 3. RACE | | | 4. DATE OF BIRTH MONTH DAY YEAR | | | 5. AGE (IN YEARS LAST BIRTHDAY) | | | 6. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | | |
| <u>White</u> | | | <u>Nebraska</u> | | | <u>44</u> | | | | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 8. CITIZEN OF WHAT COUNTRY | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | 10. IF UNDER 14 HRS MONTHS DAYS HOURS MIN | | | |
| <u>Ok.</u> | | | <u>U.S.A.</u> | | | <u>Wicomico</u> | | | | | | |
| 11. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| <u>Salisbury</u> | | | <u>Peninsula General Hospital</u> | | | <u>Domestic</u> | | | <u>Medical</u> | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b. STATE | | | 13c. CITY/TOWN | | | 13d. STREET ADDRESS | | | |
| <u>MS</u> | | | <u>Wi</u> | | | <u>Salisbury</u> | | | <u>314 CATHERINE ST.</u> | | | |
| 14. FATHER'S NAME FIRST MIDDLE | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES (YES/NONE UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | 17. INFORMANT ADDRESS | | | |
| <u>LEROY</u> | | | <u>GAINES</u> | | | <u>NO</u> | | | <u>218-30-1724 Jeffrey Smiley Sals. MD</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> 1550 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hepatitis cellular Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from <u>8/13</u> , 19 <u>79</u> , to <u>8/17</u> , 19 <u>79</u> , that (I) <u>not</u> saw the deceased alive on <u>8/17</u> , 19 <u>79</u> , and that in my <u>not</u> opinion death occurred on the date and hour and from the causes stated above. (I) did <u>not</u> view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Joseph A. Gansso</u> | | 22c. DEGREE <u>MD</u> | | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22e. DATE SIGNED <u>AUG 22 1979</u> | | | |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joseph A. Gansso</u> | | 22g. ADDRESS | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL SPECIFY | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIAL <u>Burial Service</u> | | | 23d. LOCATION CITY OR TOWN | | COUNTY STATE | | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | | 24c. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE <u>Anthony DeCredy</u> | | | | |
| <u>BP</u> | | <u>West Falls Salisbury MD</u> | | | <u>AUG 22 1979</u> | | | | | | | |
| DHMH - 16 60M 1/75 (VR A 15 (4)) | | | | | | | | | | | | |

McCormick

Estates Settlement - Settlement

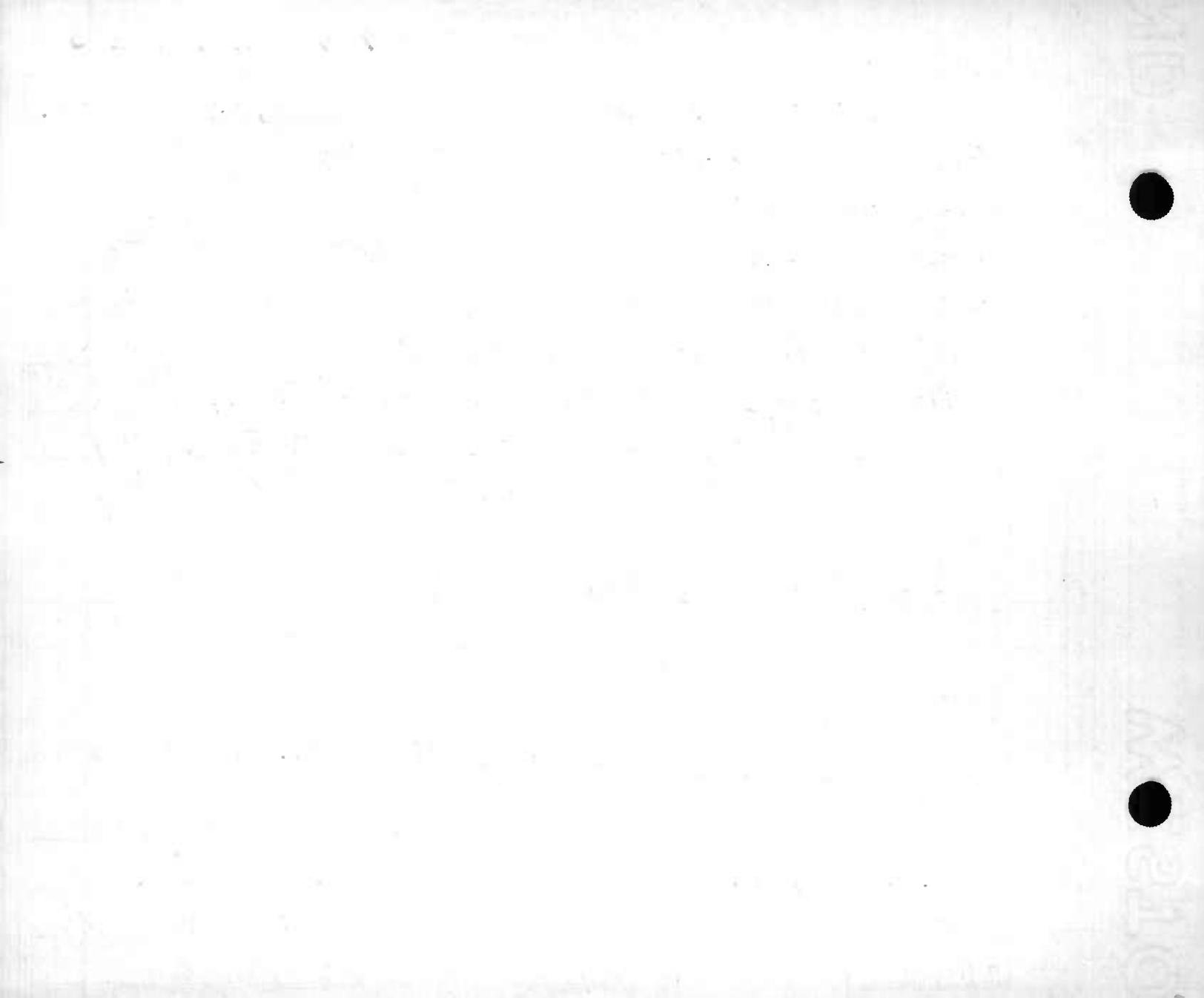
Settled by DUA

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 9 21125 | |
|--|--|---|----------------------------------|---|---|-------------------|--|---|----------------------------------|---------------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR | | | 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | |
| | | | ARIETTA HAMMOND SMITH | | | | | | AUGUST 31, 1979 | | | 9:15a.m. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | | |
| Female | | White | | 7 4 1895 | | | YRS | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO | | | 10. CITY OR TOWN OF DEATH Salisbury | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center | | | | | | | | | | | | 12a. USUAL OCCUPATION Retired School Teacher | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Wicomico | | | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13b. STATE Md | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 803 Camden Ave | | | |
| 14. FATHER'S NAME FIRST Thomas | | MIDDLE A. | | LAST Smith | | | 15. MOTHER'S MAIDEN NAME FIRST ALICE MIDDLE RUARK | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 219-36-5818 | | | 17. INFORMANT Miss Belle J. Smith | | | ADDRESS 803 Camden Ave SALISBURY MD | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ca of heart & gen. intertumor</i> | | | | | | | | | | | | 44 | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Ca of colon & breast</i> (c) <i>Ca of liver</i> | | | | | | | | | | | | 44 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) <i>S.p. wt. & temperature</i> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jun 15, 1979, to Aug. 31, 1979, that (we) last saw the deceased alive on Aug. 31, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (and did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>L. V. Maldve</i> | | 22c. DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d. DATE SIGNED 08/31/79 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. V. Maldve, M.D. | | 22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/3/1979 | | 23c. NAME OF CEMETERY OR CREMATORIAL PARSONS Cem. | | | 23d. LOCATION CITY OR OWN COUNTY STATE SALISBURY WIC. MD. | | | | | | |
| 24. FUNERAL DIRECTOR NAME Hill-Baker-Bounds | | ADDRESS SALISBURY, MD. | | | 25a. DATE REC'D. BY REGISTRAR SEP 6 1979 | | | 25b. REGISTRAR'S SIGNATURE <i>Hill-Baker-Bounds</i> | | | | | |
| DHMH-16 20M (VRA 15, 4) 7/78 | | | | | | | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM B. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR USE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 21126 |
|---|---------|--|--|---------------------------|---|---|---|--------------------------------------|-------------------------------|--------|--|----------------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF ESTI- DEATH MATED | | | MONTH | DAY | YEAR | 2b. HOUR |
| DAVID | | | L. | SMITH | | <input checked="" type="checkbox"/> | <input type="checkbox"/> | 8-29-79 | 19 | 9 | 58A | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY | 6. AGE (IN YEARS) MONTHS DAYS | 7. IF UNDER 1 YR. YRS. | 8. IF UNDER 24 HRS. HOURS MIN | 2c. DATE PRONOUNCED DEAD | | | MONTH | DAY | YEAR | 2d. HOUR |
| Male | AA | 10 30 | 25 | 53 | | <input checked="" type="checkbox"/> | <input type="checkbox"/> | 8-29-79 | 19 | 11 | M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Va. | | U.S.A. | | | | | | Wicomico | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Salisbury | | Peninsula General Hospital | | | Laborer | | | Mill | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | | | |
| Md. | | Worcester | | Pocomoke | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Rt. 1, Box 72 | | | | |
| 14. FATHER'S NAME FIRST | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME MIDDLE | | LAST | | | | |
| William | | | | Smith | | Maggie | | Taylor | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes | |
| No | | 218-20-3008 | | | Lillie Miller R.T. I Bx. 72 Pocomoke, Md. | | Congestive Heart Failure | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | (b) | | (c) | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | | | | |
| | | | | | | <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | COUNTY | STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural Causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u> TITLE (SPECIFY) Deputy MEDICAL EXAMINER | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D. ADDRESS 409 Camden Ave., Salisbury, Md. | | | | | | | | | | | | |
| 23a. FUNERAL, CREMATION, REMOVAL SPECIFY | | | 23b. DATE 9-1-79 | | | 23c. NAME OF CEMETERY OR CREMATORIUM John Neck Cem. | | | 23d. LOCATION CITY OR TOWN | | | |
| Burial | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a. DATE RECEIVED BY REC'D BY | | | 25b. REC'D BY REC'D BY | | | |
| Savage Funeral Home, New Church, Va. | | | | | | SEP 1 1979 | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 9 2 1 1 2 7 | | | |
|---|--|---------------------------------|---|--|----------------------------|--|------|---|--|--|---|---|--|
| 1 - FOR STATE REGISTRAR | | | 2a DATE OF DEATH MONTH DAY YEAR 8 AUGUST 11 1979 | | | | | | | 2b HOUR, MIN 3 30 P.M. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) ROBERT REESE SMULLEN | | | MIDDLE | | | LAST | | | | | | | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH MONTH Dec. 25, 1926 | | | YEAR | | | 6 AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS 52 YRS | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Salisbury, Md. | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | 9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | | |
| 10 CITY OR TOWN OF DEATH Salisbury | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pipe Fitter | | 12b KIND OF BUSINESS OR INDUSTRY Plumbing | |
| 13a STATE Maryland | | | 13b COUNTY Wicomico | | 13c CITY OR TOWN Salisbury | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e STREET ADDRESS 110 Prince Street | | |
| 14. FATHER'S NAME FIRST George | | | MIDDLE W. Smullen | | LAST | | | 15. MOTHER'S MAIDEN NAME FIRST Roxie | | | MIDDLE B. Phippin | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | 16b SOCIAL SECURITY NO. 218-16-7369 | | | 17. INFORMANT (wife) Mrs. Gladys M. Smullen same as 13 | | | ADDRESS | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lung Cancer 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | COUNTY STATE | | |
| 22a I certify that (I) <input type="checkbox"/> attended the deceased from 8/11/79, 1979, to 8/11, 1979, that (I) <input type="checkbox"/> last saw the deceased alive on 8/11/79, 1979, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> did / did not view the body after death | | | | | | | | | | | | 22c DATE SIGNED 8-12-79 | |
| 22b SIGNATURE Joseph A Grasso | | | 22c DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A Grasso | | | 22e ADDRESS PGHMC SALISBURY, MD 21801 | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 8/14/79 | | | 23c NAME OF CEMETERY OR CREMATORIAL Wicomico Mem. Park | | | 23d LOCATION CITY OR TOWN Salisbury | | COUNTY Wic., Maryland | | |
| 24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md. | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR AUG 15 1979 | | | 25b. REGISTRAR'S SIGNATURE John J. Grasso | | | | |
| DHMH - 16 60M 1/75 (VRA 15(4)) | | | | | | | | | | | | | |

International Organization
Economic and Social Council

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be filled in by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. | | | |
|---|--|---|--------------|---|--|-----------------------|--|--|-------------|---|------------------|--|----------------|-----------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | | | |
| <i>Harold L. Snead</i> | | | | | | <i>August 29 1974</i> | | | <i>6:13</i> | <i>M</i> | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| <i>M</i> | | <i>N</i> | | <i>7 2 1912</i> | | | <i>67</i> | | | <i>YRS.</i> | | | | | |
| 7a. BIRTHPLACE STATE OR FOREIGN COUNTRY | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | |
| <i>PA</i> | | <i>USA</i> | | | | | <i>WICOMICO</i> | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| <i>SALISBURY</i> | | <i>PENINSULA GENERAL HOSPITAL</i> | | | | | | | | | | <i>Self Emp.</i> | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS | | | 2218 CATHEDRAL | | |
| <i>PA</i> | | <i>PHL</i> | | <i>CITY</i> | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST | | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | | | ADDRESS | | | | | | | | |
| <i>William</i> | | | <i>Snead</i> | <i>Hettie</i> | | | <i>Agnes</i> | | | <i>Snead</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| <i>NO</i> | | <i>180-12-9182</i> | | <i>Agnes</i> | | | <i>Harold J. Koenigsberg</i> | | | <i>24 hrs</i> | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | (b) | | | DUE TO, OR AS A CONSEQUENCE OF | | | (c) | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | | <input type="checkbox"/> YES <input type="checkbox"/> NO | | | <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | COUNTY | STATE | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from _____ to _____, and that (I) (we) last saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, check here.) | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> | | | MEDICAL DIRECTOR <input type="checkbox"/> | | STAFF PHYSICIAN <input type="checkbox"/> | 22d. DATE SIGNED | | | | |
| 22e. PHYSICIAN'S OR ATTENDING PHYSICIAN'S SIGNATURE | | <i>David P. Largey</i> | | | 22f. ADDRESS | | | | | | <i>1974</i> | | | | |
| 23a. FUNERAL, CREMATION, REMOVAL SPEC. | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION CITY OR TOWN | | | COUNTY | STATE | | | | |
| <i>BURIAL</i> | | <i>9-5-79</i> | | <i>NORTHWOOD CEM</i> | | | <i>PHILA</i> | | | <i>PHILA</i> | <i>PA</i> | | | | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | |
| <i>Addie James JAMES FUNERAL HOME</i> | | <i>SEP 4 1979</i> | | | <i>Larry McElroy</i> | | | | | | | | | | |
| ADDRESS | | | | | | | | | | | | | | | |
| <i>PRINCESS ANN</i> | | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

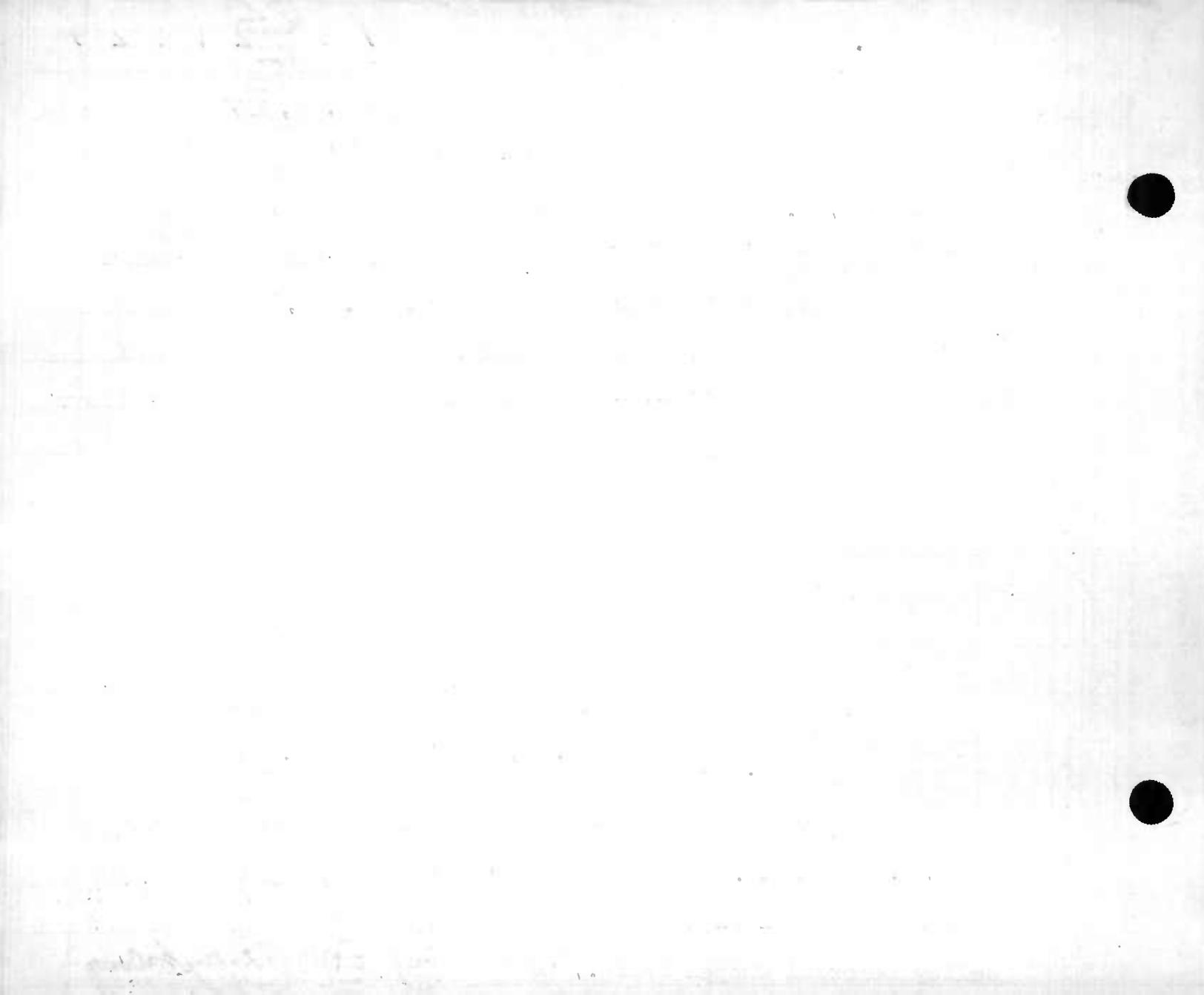
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon/papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1 - STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 9 2 1 1 2 9 | | | |
|---|--|---|-----------------|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST JAMES | MIDDLE SNEAD | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | | | | | |
| 3 SEX Male | | 4 RACE Negro | | 5 DATE OF BIRTH MONTH 8 DAY 12 YEAR 95 | | 6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | IF UNDER 24 HRS HOURS 9 MIN 00 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pungoteague, Va. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH WICOMICO, MD. | | | | | |
| 10 CITY OR TOWN OF DEATH SALISBURY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DEER'S HEAD CENTER | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Lumber | | | | | |
| 13a. STATE Md | | 13b. COUNTY Worcester | | 13c. CITY OR TOWN Berlin | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Rt. #2, Box 346 | | | |
| 14 FATHER'S NAME FIRST James | | MIDDLE Snead | | 15 MOTHER'S MAIDEN NAME LAST Alicia | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO 222-16-5645A | | 17 INFORMANT Caroline Purnell | | ADDRESS same as above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ca of prostate</i> APPROXIMATE INTERVAL BETWEEN INJURY AND DEATH 185- Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause first { DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Fr. at ② Femur | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Feb. 22, 1979</u> to <u>Aug. 22, 1979</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Aug. 22, 1979</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did/did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Maldve, M.D.</i> | | 22c. DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> | | MEDICAL DIRECTOR <input type="checkbox"/> | | STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. V. Maldve, M.D. | | 22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801 | | | | | | | | 22f. DATE SIGNED 08/22/79 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8-25-79 | | 23c. NAME OF CEMETERY OR CREMATORIAL Evergreen Cemetery | | 23d. LOCATION CITY OR TOWN Berlin Worcester Md | | COUNTY | | STATE | |
| 24 FUNERAL DIRECTOR NAME Jolley Memorial Chapel Salis., Md | | ADDRESS Jersey Road | | | | 25a. DATE REC'D. BY REGISTRAR AUG 28 1979 | | 25b. REGISTRAR'S SIGNATURE <i>John Jolley</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG NO. 9 2 1 1 3 0 | | | | | | |
|---|--|--|--|--------------------------|--|--|--|-------------------|---|--|--|--|--|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>August 23 1979</i> | | | | | | | | | 2b. HOUR <i>8:05 AM</i> | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST <i>Joseph</i> | MIDDLE <i>Francis</i> | LAST <i>STRAN</i> | 5. DATE OF BIRTH MONTH DAY YEAR <i>Jan. 4 1934</i> | | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <i>45 yrs</i> | | | 7. IF UNDER 18 YEARS MONTHS DAYS HOURS MIN <i>0 months 0 days 0 hours 0 min</i> | | | | | | |
| 3. SEX <i>Male</i> | | | 4. RACE <i>white</i> | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i> | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Salisbury</i> | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Peninsula General Hospital</i> | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Construction</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>dry wall</i> | | | |
| 13a. STATE <i>Md.</i> | | | 13b. COUNTY <i>Worcester</i> | | | 13c. CITY OR TOWN <i>Bushpocket</i> | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS | | | | | | |
| 14. FATHER'S NAME FIRST <i>Dalton</i> | | | MIDDLE <i></i> | LAST <i>Stran</i> | 15. MOTHER'S MAIDEN NAME FIRST <i>Anna Marie</i> | | | MIDDLE <i></i> | LAST <i>Baker</i> | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>yes</i> | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>156-58</i> | | | 17. INFORMANT ADDRESS <i>Mayarie Stran Bushpocket, Md</i> | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>2000</i> | | | DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hodgkin's lymphoma</i> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| | | | DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/20</i> , 19 <i>79</i> , to <i>8/23</i> , 19 <i>79</i> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <i>8/22</i> , 19 <i>79</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did <input type="checkbox"/> not view the body after death. | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Jay Russo</i> | | | 22c. DEGREE <i>MD</i> | | | | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d. DATE SIGNED <i>8-23-79</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joseph A. Russo</i> | | | 22e. ADDRESS | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE <i>8/26/79</i> | | | 23c. NAME OF CEMETERY OR CREMATORIAL <i>Odd Fellows</i> | | | 23d. LOCATION CITY OR TOWN <i>Bushpocket</i> | | | COUNTY STATE <i>Wor. Md.</i> | | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>Richard T. Watson</i> | | | 25a. DATE REC'D. BY REGISTRAR <i>AUG 27 1979</i> | | | | | | | | | 25b. REGISTRAR'S SIGNATURE <i>Frank J. Kennedy</i> | | | | | | |
| ADDRESS <i>Selbyville, Del</i> | | | | | | | | | | | | | | | | | | |

option II

and some design learning guidelines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 9 21131 |
|--|--|---|-------|---|-----------------------------------|---|--------|--|------|--------------------|--|------------------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | | |
| LESLIE B. | | | | | Tarbutton | August 28 | 1979 | | | 4:35 PM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS | | |
| male | | caucasian | | MONTH JUNE DAY 30 YEAR 1913 | | 66 | | MONTHS YRS. | | HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Maryland | | U.S. | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | WICOMICO | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| SALISBURY | | PENINSULA GENERAL HOSPITAL | | manager-bulk sales-dog food | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | |
| Maryland | | Wicomico | | Salisbury | | | | 520 J. Alabama-Oak Hill | | | | |
| 14. FATHER'S NAME FIRST | | MIDDLE | | LAST | 15. MOTHER'S MAIDEN NAME FIRST | | MIDDLE | | LAST | | | |
| George Raymond | | Tarbutton | | | Florence O. Leonard | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | ADDRESS | | | | | | |
| yes | | W.W. 11 | | 221-01-9663 | | Frances T. Tarbutton | | see item 13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c).) | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident secondary to</u> <u>4148</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pain Cervical outlet syndrome & chronic</u> (c) <u>Congestive heart failure.</u> | | | | | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>old antroscopic right inguinal hernia with left Bulky Brachio Bilia.</u> | | | | | | | | | | | | |
| 19a. MEDICAL CERTIFICATION | | 19b. DATE OF OPERATION | | 19c. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/18/78</u> to <u>8/28/79</u> , that (I) (we) last saw the deceased alive on <u>8/28/79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | | |
| <u>J. Tarbutton</u> | | | | M.D. | | ATTENDING PHYSICIAN | | MEDICAL DIRECTOR | | STAFF PHYSICIAN | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | |
| Joseph Z Badros | | 229 Florida Ave | | Salisbury Maryland | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIAL | | 23d. LOCATION CITY OR TOWN | | COUNTY | | STATE | | |
| Burial | | 8-31-1979 | | Spring Hill | | Easton, Talbot, Maryland | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| Newnam Funeral Home | | Easton, Md. | | SEP 4 1979 | | <u>Rufus McElroy</u> | | | | | | |

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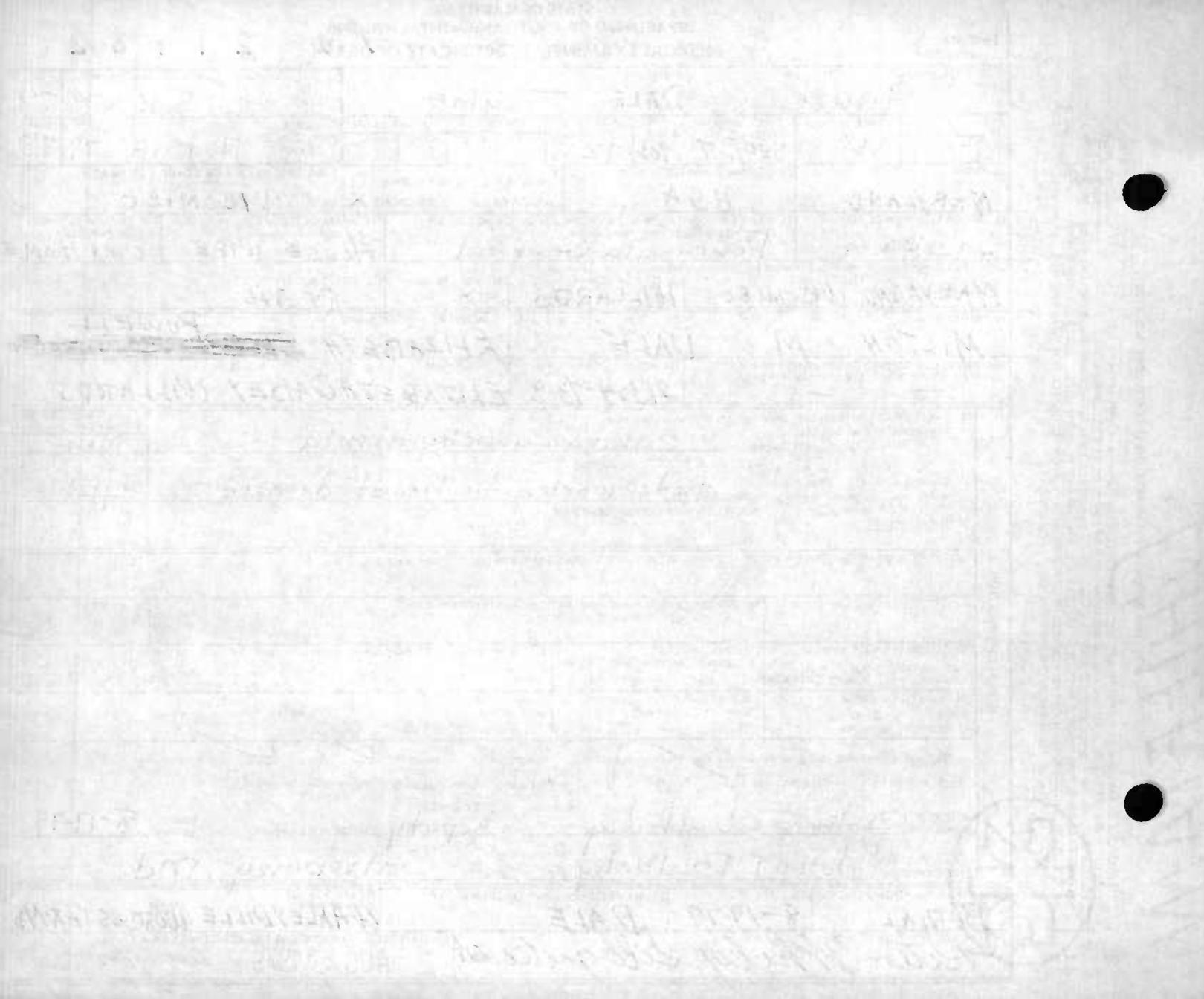
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21132
REG. NO.1 - STATE
REGISTRAR

| | | | | | | | | |
|--|----------|--|------------------------------------|---|---|---|---|----------------|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF ESTI- DEATH MATED | 2b. MONTH DAY YEAR | 2b. HOUR PM | |
| <i>Annie</i> | | <i>DALE</i> | <i>Taylor</i> | | <input type="checkbox"/> | <i>8 16 1979</i> | <i>7:2 PM</i> | |
| 3. SEX | 4 RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN | 2c. DATE PRONOUNCED DEAD | 2d. MONTH DAY YEAR | 2d. HOUR PM |
| <i>F</i> | <i>W</i> | <i>SEPT. 7 1906</i> | <i>72 yrs.</i> | | | <i>Aug. 16 1979</i> | <i>7:2 PM</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>WICOMICO</i> | | |
| <i>MARYLAND</i> | | <i>USA</i> | | | | MD. | | |
| 10. CITY OR TOWN OF DEATH <i>Salisbury</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Peninsula General</i> | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSE WIFE</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i> | |
| 13a. STATE <i>MARYLAND</i> | | 13b. COUNTY <i>WICOMICO</i> | | 13c. CITY OR TOWN <i>WILLARDS</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS <i>RT 346</i> | |
| 14. FATHER'S NAME <i>MILTON</i> FIRST <i>M.</i> MIDDLE <i>DALE</i> LAST | | 15. MOTHER'S MAIDEN NAME <i>ELIZABETH</i> | | | 16. ADDRESS <i>POWELL</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>—</i> | | 16b. SOCIAL SECURITY NO. <i>213-47-313</i> | | 17. INFORMANT <i>ELIZABETH DAISEY WILLARDS</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrhythmia</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>min</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>arteriosclerotic heart disease</i> yrs DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o). | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | COUNTY | STATE |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE <i>John G Bulkeley</i> | | TITLE (SPECIFY) M.D. <i>Deputy</i> MEDICAL EXAMINER | | | DATE SIGNED <i>8-17-79</i> | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>John T Bulkeley</i> | | ADDRESS <i>Salisbury, Md.</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL <i>BURIAL</i> | | 23b. DATE <i>8-19-79</i> | | 23c. NAME OF CEMETERY OR CREMATORIAL <i>DALE</i> | | 23d. LOCATION CITY OR TOWN <i>WALEYVILLE</i> COUNTY <i>WORCESTER</i> STATE <i>MD.</i> | | |
| 24. FUNERAL DIRECTOR <i>Peter Whaley Silbergillcase</i> | | 25a. DATE REC'D. BY REGISTRAR <i>AUG 23 1979</i> | | | 25b. REGISTRAR'S SIGNATURE <i>Holiday McCrady</i> | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 3 FOR YOUR OWN USE. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is
rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours of
death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at office.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | 9 | 21 | 13 | 3 | | |
|---|--|--|---|-------------|---|--|--|---|--|-----|--|---|-------|---|---|--|--|
| | | | | | | | | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | | | | | |
| <u>Dorothy</u> | | | <u>WARD</u> | | <u>Taylor</u> | <u>August 7 1979</u> | | | | | 1979 | 9 35 AM | | | | | |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 14 YRS MONTHS DAYS | | | | | | |
| <u>FEMALE</u> | | | <u>Negro</u> | | <u>9 13 23</u> | | | <u>55</u> | | | IF UNDER 24 HRS MONTHS DAYS | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | | | | |
| <u>Baltimore, Md.</u> | | | <u>USA</u> | | | | | <u>Wicomico</u> | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | |
| <u>Salisbury</u> | | | <u>Peninsula General Hospital</u> | | | | | | | | | <u>Retired teacher</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY <u>education</u> | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS <u>P.O. Box 400</u> | | | | | | |
| <u>Md</u> | | | <u>Wicomico</u> | | <u>Salisbury</u> | | | | | | <u>West Road Salisbury, Md.</u> | | | | | | |
| 14. FATHER'S NAME FIRST | | | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | | | MIDDLE | 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | | |
| <u>James</u> | | | <u>J.</u> | <u>WARD</u> | <u>Willie</u> | | | | <u>Edward Taylor</u> | | | <u>SAME AS above</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18, 1b, and c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> | | | | | |
| <u>431-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | <u>Massive Right Intracerebral Haemorrhage</u> | | | | | |
| { DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive vascular disease</u> | | | | | | | | | | | | | | | | | |
| { DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Long Standing Hypertension - Obesity. Previous Stroke w/o recovery</u> | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | COUNTY | STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/1/79</u> 19 to <u>8/7/79</u> 19, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>8/7/79</u> 19, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did <input type="checkbox"/> not view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Bal Agarwal</u> | | | 22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | DATE SIGNED <u>8/7/79</u> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BAL AGARWAL</u> | | | 22e. ADDRESS <u>P.C.H. Salisbury Md 21801</u> | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | | 23b. DATE <u>8-79</u> | | | 23c. NAME OF CEMETERY OR CREMATORIAL <u>Springhill Memory Gardens</u> | | | 23d. LOCATION CITY OR TOWN <u>Salisbury</u> | | | COUNTY | STATE | | | | |
| 24. FUNERAL DIRECTOR NAME <u>Jolley Memorial Chapel</u> | | | ADDRESS <u>Rt. #2 Jersey Rd.</u> | | | 25. DATE REC'D. BY REGISTRAR <u>AUG 8 1979</u> | | | 26. REGISTRAR'S SIGNATURE <u>Patricia Kennedy</u> | | | | | | | | |

Information

Section 101(a)(2) of the Act, including the following:

101 DUA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|---|--|---|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | 2a DATE OF DEATH MONTH DAY YEAR | | | | | | | 2b HOUR | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | FIRST | | MIDDLE | | 5 DATE OF BIRTH MONTH DAY YEAR | | | 6 AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS | |
| EVELYN FRANCES (Brown) TAYLOR | | | | | | | 10/8/1925 | | | 53 YRS | |
| 3 SEX Female | | | 4 RACE White | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | 10 CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housework | | | 12b KIND OF BUSINESS OR INDUSTRY none | |
| 13a STATE Maryland | | | 13b COUNTY Wicomico | | 13c CITY OR TOWN Salisbury | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e STREET ADDRESS 610 E. Isabella St. | |
| 14 FATHER'S NAME John | | | MIDDLE William | | LAST Brown | | 15 MOTHER'S MAIDEN NAME Berdie | | | LAST Esther Phippin | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b SOCIAL SECURITY NO 218-20-5582 | | 17 INFORMANT (son) Mr. John Earl Rathel, Jr., Salisbury, Md. | | | ADDRESS 609 Baker St., Salisbury, Md. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b). with generalized metastasis DUE TO, OR AS A CONSEQUENCE OF (c). Carcinoma of the lung | | | | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Chronic obstructive Pulmonary Disease | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN COUNTY STATE | | |
| 22a I certify that (I) (this hospital) attended the deceased from 8/17/79 19 79 to 8/17/79 19 79, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE Helen M. Baldado | | | 22c DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d DATE SIGNED 9/13/79 | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Helen M. Baldado | | | 22e ADDRESS 237 Florida Ave, Salisbury | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 8/13/79 | | | 23c NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| 24 FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md. | | | 25a DATE REC'D. BY REGISTRAR ADDRESS HOLLOWAY FUNERAL HOME, Salisbury, Md. | | | 25b. REGISTRAR'S SIGNATURE AUG 21 1979 history McElroy | | | | | |

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missouri

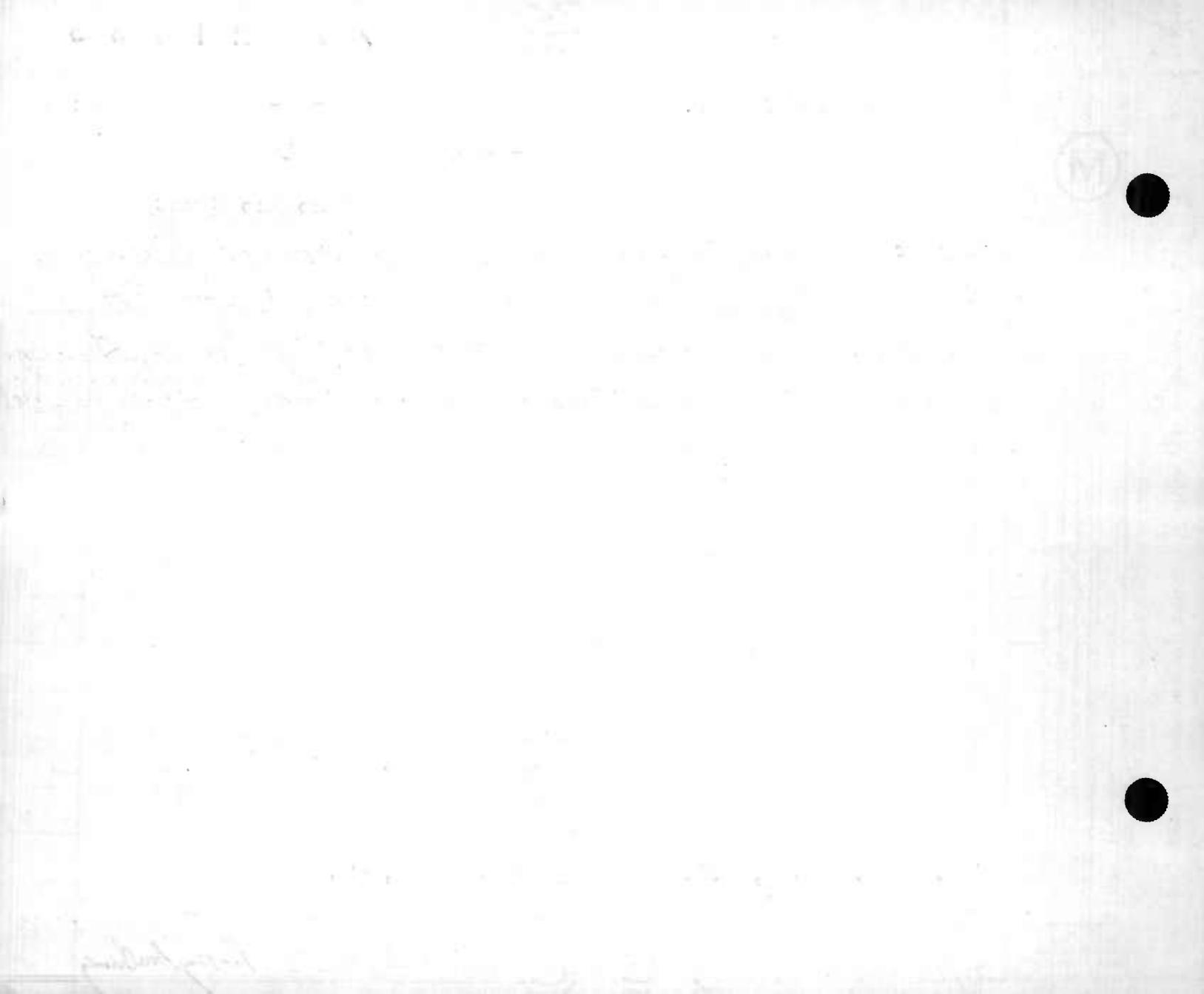
Missouri General Information

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3
should be detached for use as the burial/trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 7 days.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
should be detached for use as the burial/trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 7 days.
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 9 2 1 1 3 5 | | |
|---|--|---|---|---|--|---|---|--|---|---|---|---|--|--|
| 1 - STATE REGISTRAR | | | 20. DATE OF DEATH MONTH DAY YEAR 8-24-79 | | | | | | | | | 21. HOUR 15 12: P.M. | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE | | | LAST | | | 20. DATE OF DEATH MONTH DAY YEAR | | | 21. HOUR 15 12: P.M. | | |
| MARGARET C. THOMS | | | | | | | | | 8-24-79 | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE IN YEARS LAST BIRTHDAY | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | |
| F | | W | | 12-3-98 | | | 80 YRS. | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | Wicomico County | | | | |
| Penn. | | U.S.A. | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | Salisbury SALISBURY NURSING HOME HOUSEWIFE Own Home | | | | |
| Salisbury | | Salisbury Nursing Home | | | | | | | | | | | | |
| 13a. STATE Penn. | | 13b. COUNTY Allegheny Pittsburgh | | 13c. CITY OR TOWN Pittsburgh | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1708 Riato St. | | | | | |
| 14. FATHER'S NAME FIRST Edward | | MIDDLE Klicker | | 15. MOTHER'S MAIDEN NAME Margaret Catherine Bingham | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. No - | | 16c. INFORMANT De- Oliver Thomas | | | 16d. ADDRESS 8 Jackson Rd Salisbury Md | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Arteriosclerotic cardiovascular unknown | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Disease | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-24-79 to 8-24-79, 1979, that (I) (we) last saw the deceased alive on 8-24-79, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE DEGREE | | | | | | | | | | | | | | |
| 22c. DATE SIGNED 8-24-79 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | | |
| WILBER R. ELLIS, M.D. | | | SALISBURY, MD. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE 8-28-1979 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Mt Royal Cemetery | | | 23d. LOCATION Salisbury, Allegany Penn | | | | | |
| Burial | | | Mt Royal Cemetery | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Hill-Baker-Bownds | | | Salisbury Md. | | | AUG 28 1979 | | | Hill-Baker-Bownds | | | | | |



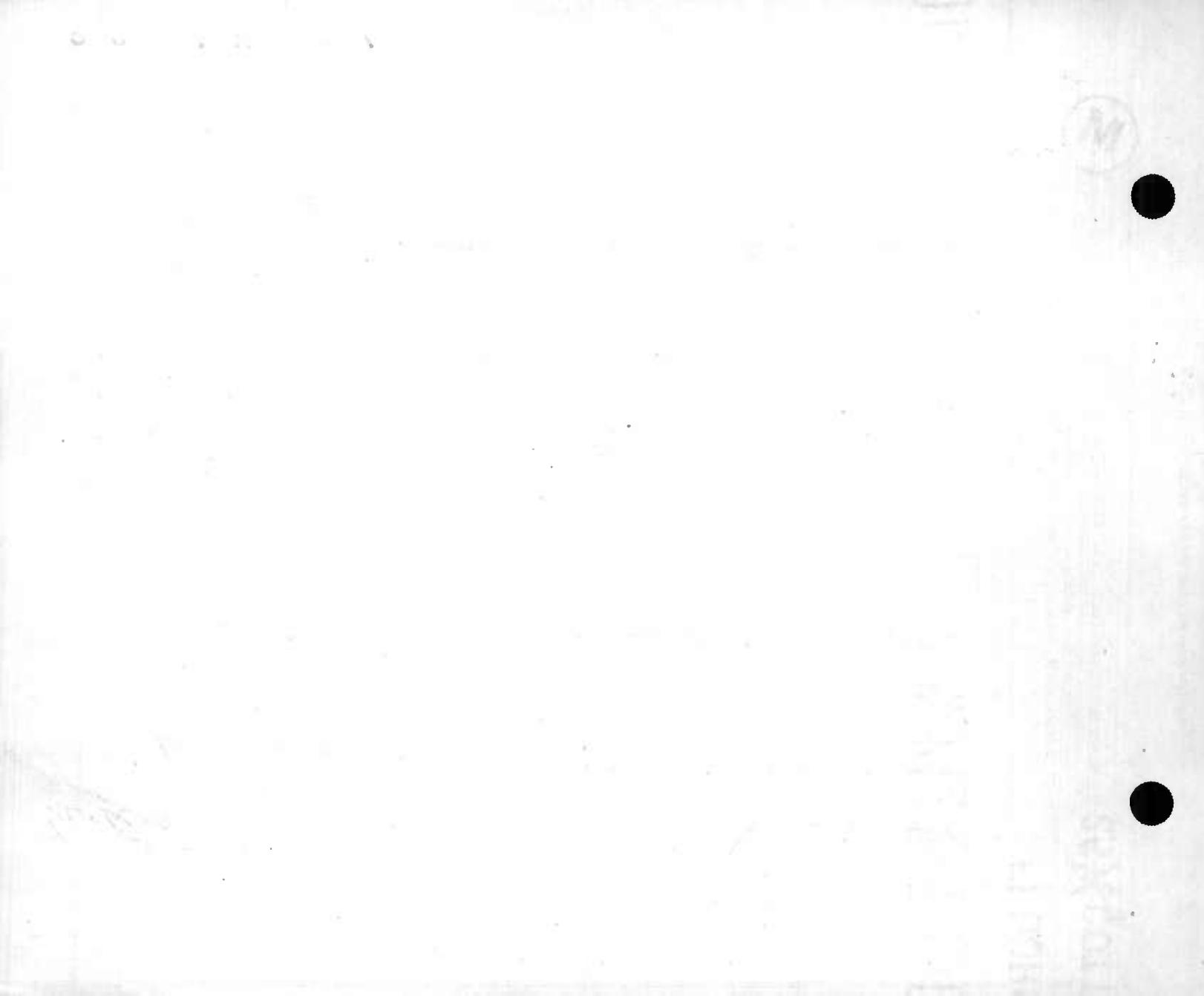
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be filed within 72 hours.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 9 2 1 1 3 6 | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|--------|---|--|--------------------|--------|------|-----------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | 2. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| Nina Louise | | | | | | | | | Tingle | | | August 28 | | 1979 | | | 4:30 P.M. | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS | | | | |
| F | | | White | | | MONTH 10 DAY 26 YEAR 1902 | | | 76 | | | MONTHS 76 | | DAYS 0 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | | | | |
| Wicomico-Md. | | | U.S.A. | | | | | | WICOMICO | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| SALISBURY | | | PENINSULA GENERAL HOSPITAL | | | Housewife | | | Home | | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | | | | |
| Maryland | | | Wicomico | | | Salisbury | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 104 Justice Ave. | | | | | | |
| 14. FATHER'S NAME FIRST | | | MIDDLE | | | LAST | | | 15. MOTHER'S MAIDEN NAME FIRST | | | MIDDLE | | | LAST | | | |
| Theodore | | | Parsons | | | Nicholson | | | Mary | | | Catherine | | | Marvel | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | 313 Brookdale Rd. | | | | | | |
| No | | | 214-10-8054 | | | Mrs. June T. Wynn | | | Salisbury, Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH mos. | | | | | | |
| 4416 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Claudia annwyn</i> (c) <i>1/wk</i> | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 8-28-79 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Same | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | COUNTY | STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-28-79 to 8-28-79, that (I) (we) last saw the deceased alive on 8-28-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I did not) view the body after death. | | | | | | | | | | | | 22c. DATE SIGNED 8-29-79 | | | | | | |
| 22b. SIGNATURE <i>Jen Yann</i> | | | 22c. DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. KENT CARNEY | | | 22e. ADDRESS 233 FLORIDA AVE SALISBURY MD. 21801 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 8-31-79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Cemetery | | | 23d. LOCATION CITY OR TOWN Chestertown | | COUNTY | STATE Maryland | | | | | | |
| 24. FUNERAL DIRECTOR NAME Holloway Funeral Home | | | ADDRESS Salisbury Maryland | | | 25a. DATE REC'D. BY REGISTRAR SEP 4 1979 | | | 25b. REGISTRAR'S SIGNATURE <i>Holloway</i> | | | | | | | | | |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 9 2 1 1 3 7 | | | | | |
|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 20. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | | | | |
| | | | MARTHA VIRGINIA Townsend | | | | | | August 9 1979 | | | 3:30 P.M. | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 18 YEARS MONTHS DAYS HOURS MIN. | | | | | |
| Female | | | White | | | May 11, 1894 | | | 85 | | | | | | | | |
| 7a. BIRTHPLACE STATE OR FOREIGN COUNTRY | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 | | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | | USA | | | | | | | | | Wicomico | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| Salisbury | | | Peninsula General Hospital | | | Seamstress | | | Shirt Mfg. | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS | | | | | |
| Maryland | | | Wicomico | | | Salisbury | | | | | | 708 Riverside Drive | | | | | |
| 14. FATHER'S NAME | | | LAST | | | 15. MOTHER'S MAIDEN NAME | | | LAST | | | | | | | | |
| William H. | | | Purcell | | | Mary (Molly) | | | Fields | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT (daughter) ADDRESS | | | 18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| No | | | 214-10-7346 | | | Mardela, Md. | | | 486- | | | | | | | | |
| Mrs. Madeline M. Mitchell | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line items 1b and c) PART I. DEATH WAS CAUSED BY <i>Pneumonia</i> | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>486-</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (b), DUE TO, OR AS A CONSEQUENCE OF (c), | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Congestive heart failure, Agonoma</i> | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>8/8/79</i> to <i>8/9/79</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not move the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Oswald Burton</i> | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED <i>8/9/79</i> | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 8/13/79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery | | | 23d. LOCATION CITY OR TOWN Salisbury, Md. | | |
| 24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, | | | ADDRESS Salisbury, Md. | | | 25a. DATE REC'D. BY REGISTRAR AUG 13 1979 | | | 25b. REGISTRAR'S SIGNATURE <i>Holloway Funeral Home</i> | | | | | | | | |

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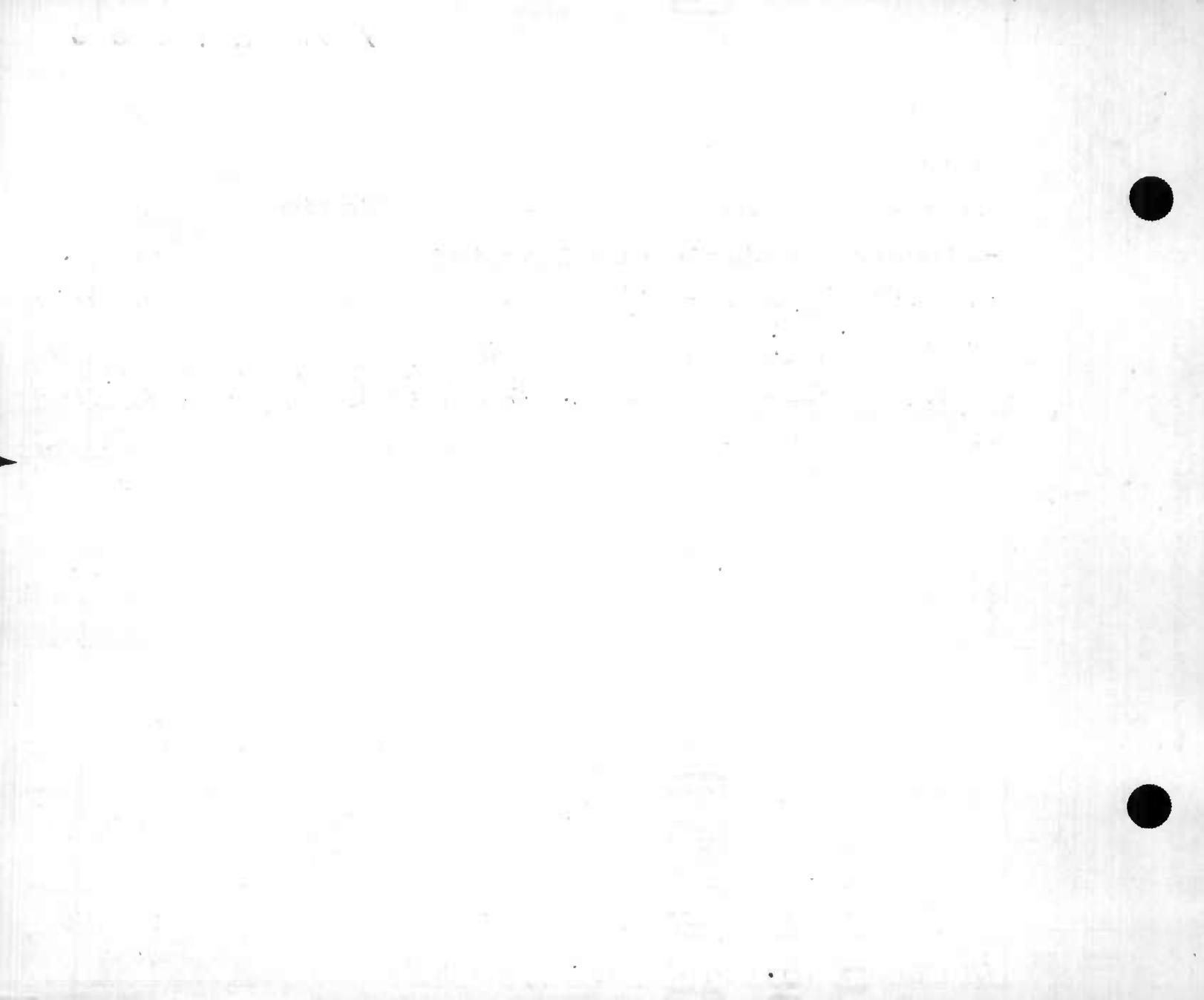
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be filed with the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 9 2 1 1 3 8 | | | | |
|---|--|--|---|------------------|---------|--|---------------------------------|--|---|---|---|-----------------|-----|------------------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | | |
| Charles Edward | | | | | TRIBECK | AUGUST 31, 1979 | | | | | | | | |
| 3. SEX | | | 4 RACE | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| MALE | | | white | MONTH DAY YEAR | | | 72 | | | MONTHS | DAYS | HOURS | MIN | |
| 7a. BIRTHPLACE COUNTRY | | | 7b. CITIZEN OF WHAT COUNTRY? | | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 7c. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Canada | | | U.S.A. | | | | | | Wicomico | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Salisbury | | | Peninsula General Hospital | | | Painter | | | Self Emp. | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS | | | | | |
| Maryland | | | Wicomico | | | | | | 404 S. Camden Ave | | | | | |
| 14. FATHER'S NAME | | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| Thomas Charles | | | | | Tribeck | Lily | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | | 17. INFORMANT | | | ADDRESS | | | | | |
| NO | | | 213-24-2000 | | | Bill Tribeck | | | RENTAL BOX 382 Salisbury, MD 21801 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| IMMEDIATE CAUSE (a) 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | Car Capillary Shock | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) CVD | | | | | | | | | | Summer | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | 103r | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | COUNTY | STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above, (I) (we) did (did not) view the body after death. | | | | | | | | | | 19 18 to 8/31 19 19, that (I) (we) last | | | | |
| and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | ADDRESS | PGH | | | 8-31-79 |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION CITY OR TOWN | | | COUNTY | | |
| Burial | | | 9/2/1979 | | | Springhill Mem & C | | | Hebron | | | Wic Md | | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Hill-Baken-Bounds, Salisbury, Md. | | | | | | SEP 6 1979 | | | Larry McBrady | | | | | |



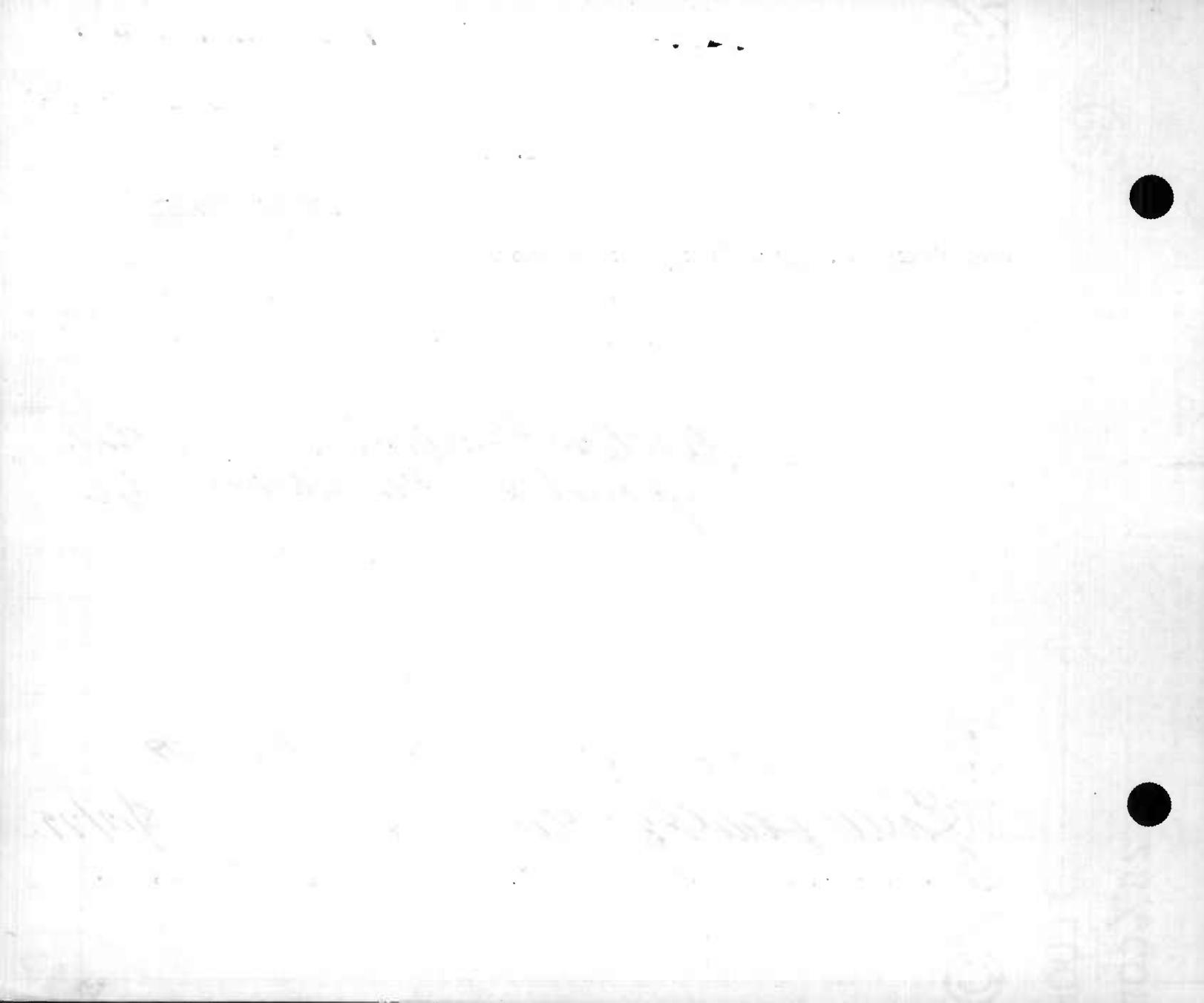
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Please be reponed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 9 2 1 1 3 9 | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--------|---|----------------------|---------|---|--|--|----------------|--|--|--|--------------------------------|--|------------------------------|--|
| 1 - STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR 8-16-79 | | | | | | | 2b. HOUR AM 11:30 | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE | | | LAST | | 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR 8-17-00 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | |
| CATHERINE Margaret | | | | | | TURNER | | F | | | W | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO COUNTY MD. | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury Md. | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Salisbury Nursing Home | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY none | | | | | | | | | | | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Wicomico | | | 13c. CITY OR TOWN Salisbury | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS Ocean City Road | | | | | | | | | | |
| 14. FATHER'S NAME FIRST George | | | MIDDLE | | | LAST Hudson | | | 15. MOTHER'S MAIDEN NAME FIRST Mary | | | MIDDLE | | | LAST Beauchamp | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 213-74-3221 | | | 17. INFORMANT Mr. Henry S. Niblett | | | ADDRESS 144 Pine Tree Ave. | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 10, 1b, and c.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | 4340 | | | Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | DUE TO, OR AS A CONSEQUENCE OF (b) generalized ulcerin sclerosis | | | Approximate Interval Between Onset and Death Satis Year | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/15/79 to 8/16/79, that (I) (we) last saw the deceased alive on 8/15/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (Did) (did not) view the body after death. | | | | | | | | | 22b. DATE SIGNED 8/17/79 | | | | | | | | | | | | | |
| 22c. SIGNATURE DR. EARL M. BEARDSLEY | | | DEGREE M.P. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22e. ADDRESS RT. 50 & CIVIC AVE., SALISBURY, MD. | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 8/19/79 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Mem. Park | | | 23d. LOCATION CITY OR TOWN Salisbury, Wic., Maryland | | | COUNTY STATE | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Holloway Funeral Home, Salisbury, Md. | | | ADDRESS | | | 25a. DATE RECEIVED BY REGISTRAR OR REGISTRAR'S SIGNATURE AUG 21 1979 | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| DHMH-16 20M (VRA 15, 4) 7/78 | | | | | | | | | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of arrival with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at office:

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG NO. 9 21140 | |
|--|--|--|-----------------|---|--|-----------------|--|-----------------|--|--------------|---------------------|-----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | FIRST Ralph | MIDDLE James | LAST Webster | 2a. DATE OF DEATH August 28, 1979 | MONTH AUGUST | DAY 28 | YEAR 1979 | 2b. HOUR 12 20 M | | |
| 3. SEX <i>Male</i> | | 4. RACE White | | 5. DATE OF BIRTH MONTH 6 DAY 9 YEAR 1916 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 | | 7. IF UNDER 1 YEAR MONTHS YRS | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | 10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Power Operator DuPont | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula Geneeral Hospital | | 12a. KIND OF BUSINESS OR INDUSTRY ry | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Calvin Drive Rt. #7 Salisbury | | | | |
| 14. FATHER'S NAME FIRST Luther | | MIDDLE J. | LAST Webster | 15. MOTHER'S MAIDEN NAME FIRST Essie Emily | | | 16. ADDRESS Maryland Taylor | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 221-10-1575 | | 17. INFORMANT Mrs. Stella A. Webster | | | 18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 1629 DUE TO, OR AS A CONSEQUENCE OF (b) IMMIGRATION LUNG CANCER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ | | | | | | | | | | | | 6 MONTHS | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from AUGUST 25, 1979, to AUGUST 28, 1979, that (we) last saw the deceased alive on AUGUST 27, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>E.H. Klopp MD.</i> | | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 8/29/79 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD H. KLOPP | | 22e. ADDRESS Peninsula Gen. Hosp. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8-31-79 | | 23c. NAME OF CEMETERY OR CREMATORIAL Springhill Mem. Gardens | | | 23d. LOCATION CITY OR TOWN Salisbury | | COUNTY | | STATE | | |
| 24. FUNERAL DIRECTOR NAME Holloway Funeral Home | | ADDRESS P.O. Box 11140 Salisbury, Md. | | | 25a. DATE REC'D. BY REGISTRAR AUG 29 1979 | | 25b. REGISTRAR'S SIGNATURE <i>H. H. Johnson</i> | | | | | | |

on been

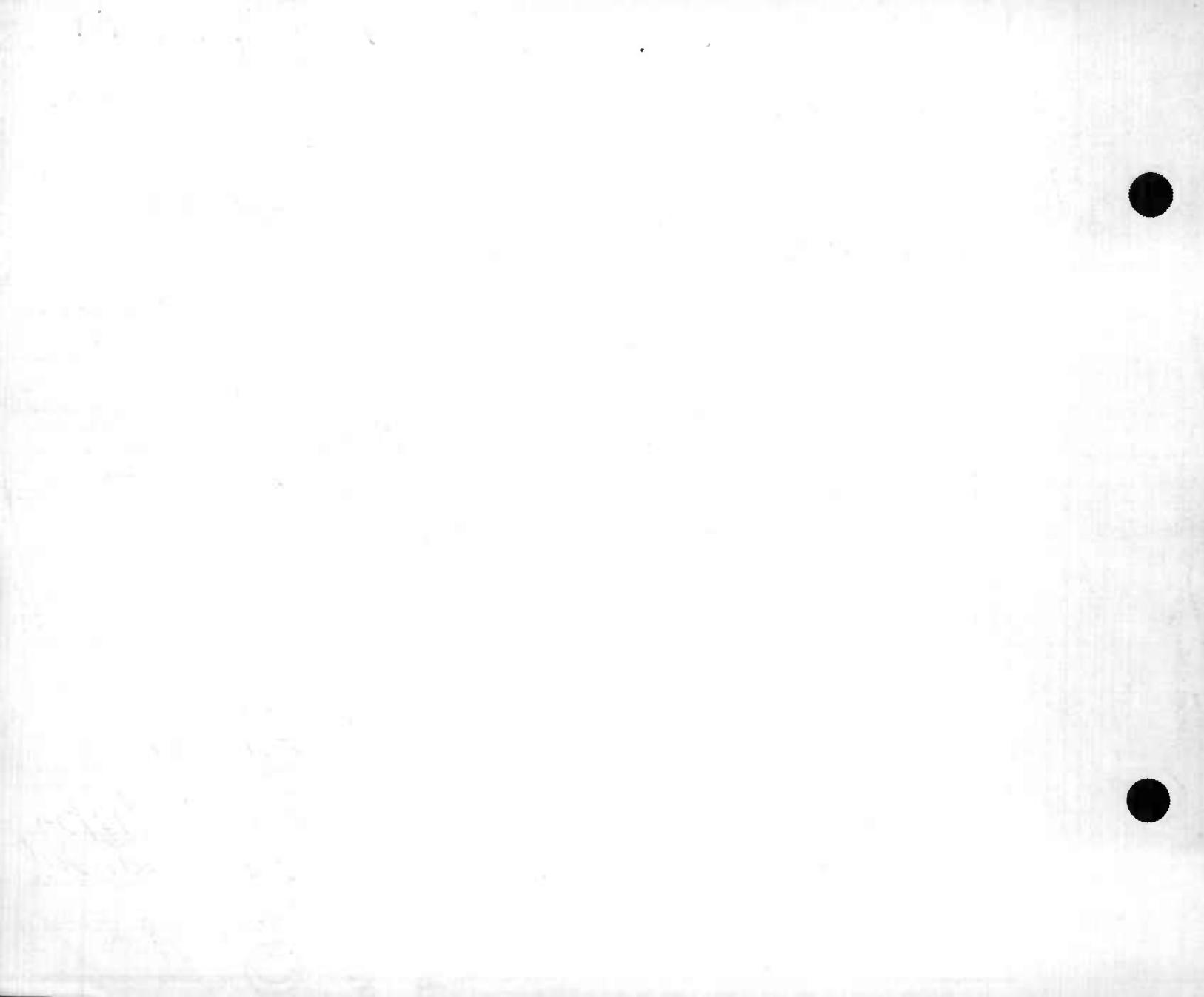
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 9 2 1 1 4 1 | | |
|---|--|---|--|--|--|--|--------------------------------------|---|-----------------------------------|---|---------------------------------------|-----------------------------------|
| | | | | | | | | | | REG. NO. | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | FIRST | MIDDLE | LAST | 2. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | |
| Montgomery | | | | | | West | 8/9/79 | | | | 7:30 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN | |
| F | | W | | March 27, 1879 | | | 100 | | | | | |
| 7a. BIRTHPLACE COUNTRY | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | |
| Salisbury, Md. | | USA | | | | | Wicomico | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Salisbury | | Wicomico Nursing Home. | | | | | | | | Housewife | | none |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | | | | | 213 Holland Ave. | | |
| 14. FATHER'S NAME FIRST William | | | | MIDDLE J. | LAST Phipps | 15. MOTHER'S MAIDEN NAME FIRST Mary | | | | MIDDLE Ellen | LAST Jones | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT (daughter) Mrs. Amy Cline, Hyattsville, Md. | | ADDRESS | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| No | | | | | | 6905 22nd Place | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line) (a), (b), (c) (d) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | | | | | | | | Cerebral vascular accident | | |
| 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | (b) Generalized arteriosclerosis | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis | | | | | | | | | | (c) AR amputation of RT by | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-10 19 76 to 8-9 19 79, that (I) (we) last saw the deceased alive on 8-8 19 79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE A.C. Mitchell | DEGREE | |
| 22c. ATTENDING PHYSICIAN <input type="checkbox"/> | | | 22d. MEDICAL DIRECTOR <input type="checkbox"/> | | | 22e. STAFF PHYSICIAN <input type="checkbox"/> | | | 22f. DATE SIGNED 8/13/79 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 8/13/79 | | 23c. NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery | | | 23d. LOCATION CITY OR TOWN Salisbury, Wicomico, Maryland | | 23e. COUNTY Wicomico | 23f. STATE Maryland | |
| 24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md. | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR AUG 15 1979 | 25b. REGISTRAR'S SIGNATURE Loyalty | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 9 2 1 1 4 2 | | | |
|--|--|---|--------|---|--------------------------|---|---------|--|-----------------------------------|---|-----------------------|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | |
| ESTHER L. WIDDOWSON | | | | | | AUGUST 30, 1979 | | | | | | 10:00am | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| Female | | White | | Sept. 22, 1897 | | 81 | | | YRS. | | MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | | |
| Iowa | | U. S. | | | | WICOMICO, | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| SALISBURY | | DEER'S HEAD CENTER | | | | House wife | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS RFD. | | | | | |
| Maryland | | Somerset | | Westover | | | | | | | | | |
| 14. FATHER'S NAME | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | | FIRST | | MIDDLE | | LAST | |
| | | August | | Leibrand | Regina | | | | | | | Wetter | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | ADDRESS | | | | | | |
| no | | | | Kenneth Widdowson, Princess Anne, Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) <i>Adeno carcinoma of Colon + metastasis to the liver</i> | | | | | | | | | | 21/79 | | | |
| 1539 Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause first. | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ { DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/30/79</i> to <i>8/30/79</i> , that (I) (we) last saw the deceased alive on <i>8/29/79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Inja Joe Hwang</i> | | DEGREE <i>MD</i> | | ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <i>8/30/79</i> | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Inja Joe Hwang, M.D.</i> | | 22e. ADDRESS <i>Deer's Head Center, Salisbury, Md. 21801</i> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIALTY) | | 23b. DATE <i>9/31/79</i> | | 23c. NAME OF CEMETERY OR BURIAL SITE <i>Bethany Cemetery</i> | | 23d. LOCALITY CITY OR TOWN <i>Chesapeake</i> | | COUNTY <i>Anne Arundel</i> | | STATE | | | |
| 24. FUNERAL DIRECTOR <i>Brent L. Hennion</i> | | ADDRESS <i>Princess Anne</i> | | 25a. DATE REC'D. BY REGISTRAR <i>SEP 4 1979</i> | | 25b. REGISTRAR'S SIGNATURE <i>Hector McCreary</i> | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN! The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 9 2 1 1 4 3 | | | | |
|---|--|--|---------------------------------------|--|---|-------------------|--|---|---------------------------------|--|-------------------------------------|---|-------|------|--|--|
| 1 - FOR STATE REGISTRAR | | | 1 DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a DATE OF DEATH MONTH DAY YEAR | | | 2b HOUR | | | | |
| | | | <i>Willard Joseph Woodrow Willard</i> | | | | | | AUGUST 30 1979 | | | 10 AM | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH MONTH DAY YEAR | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | 7 IF UNDER 1 YEAR | | 8 IF UNDER 24 HRS | | | | |
| Male | | White | | Aug. 6, 1901 | | | 77 | | | MONTHS | YEARS | MONTHS | HOURS | MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | | MD. | | | | | | |
| New York | | USA | | | | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH Salisbury | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital | | | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | |
| | | | | | | | | Retired Plumber | | | Plumbing | | | | | |
| USUAL RESIDENCE IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION | | | | | | | | | | | | | | | | |
| 13a STATE Maryland | | 13b COUNTY Wicomico | | 13c CITY OR TOWN Salisbury | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e STREET ADDRESS 521 Alabama Ave. | | | | | | |
| 14 FATHER'S NAME FIRST (unknown) | | MIDDLE | | LAST Willard | | | 15 MOTHER'S MAIDEN NAME FIRST (unknown) | | | MIDDLE | | LAST (unknown) | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 1920 - 1924 | | 16c | | | 17 INFORMANT Mrs. Thelma C. Willard (wife) same as 13 | | | ADDRESS | | | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for 10, 11, and 12 PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| <i>4140</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | | | <i>Cardiopulmonary Arrest</i> | | | | |
| { (b) <i>Hypertension</i> | | | | | | | | | | | | Hours: | | | | |
| { (c) <i>Congestive Heart Failure, Atherosclerotic Heart Disease</i> | | | | | | | | | | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? | | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET | | | CITY OR TOWN | | COUNTY | | STATE | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <i>7/24/79</i> , 19 <i>8/1/79</i> , to <i>8/1/79</i> , 19 <i>79</i> , that (I) was lost saw the deceased alive on <i>8/1/79</i> , 19 <i>79</i> , and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) did not view the body after death | | | | | | | | | | | | 22c DATE SIGNED <i>8/1/79</i> | | | | |
| 22b SIGNATURE <i>Slaggar MD</i> | | 22d DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | | |
| 22e PHYSICIAN'S NAME (TYPE OR PRINT) <i>D SAGGAR MD</i> | | 22f ADDRESS <i>547 Riverside Drive Suite E Salisbury</i> | | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL SPECIES Burial | | 23b DATE 8/4/79 | | | 23c NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery | | | 23d LOCATION CITY OR TOWN Salisbury, Wicomico, Md. | | COUNTY | | STATE | | | | |
| 24 FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Maryland | | ADDRESS | | | 25a DATE REC'D. BY REGISTRAR AUG 6 1979 | | | 25b REGISTRAR'S SIGNATURE <i>Henry Melody</i> | | | | | | | | |

1990-1991 Academic Year
Graduate Studies

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 9 2 1 1 4 4 | |
|---|--|---|-------|--|------|------------------|--|-----------|-----------|---|--|---|--|
| 1. DECEASED NAME (TYPE OF PRINT) | | | FIRST | MIDDLE | LAST | 2a DATE OF DEATH | MONTH | DAY | YEAR | 2b HOUR | | | |
| <i>mary Elizabeth Windsor</i> | | | | | | <i>August 1</i> | <i>1979</i> | <i>12</i> | <i>45</i> | <i>M</i> | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | | 6 AGE (YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | | |
| FEMALE | | WH ITE | | SEPT. 2, 1901 | | | 77 | | | MONTHS DAYS | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 | | | MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | | IF UNDER 24 HRS | | | |
| MD. | | U.S.A. | | | | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | MONTHS HOURS MIN | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Salisbury | | Peninsula General Hospital | | | | | | | | | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | 13e STREET ADDRESS | |
| 13a STATE MD. | | 13b COUNTY SOMERSET | | 13c CITY OR TOWN PRINCESS ANNE | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e STREET ADDRESS | | | |
| 14 FATHER'S NAME FIRST JAME A., MIDDLE HOLLAND LAST | | 15 MOTHER'S MAIDEN NAME FIRST MARY E. CLUFF MIDDLE LAST | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 16c | | | 17 INFORMANT MRS CARLOS BOZMAN | | | ADDRESS PRINCESS ANNE, MD. | | | |
| NO | | 213-01-5540 | | | | | | | | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c) PART I. DEATH WAS CAUSED BY | | | | | | | | | | | | 19. IMMEDIATE CAUSE (a) | |
| 4240 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Heart Disease</i> | |
| | | | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (c) <i>Artificial Cardiopulmonary Resuscitation</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | <i>Heart - Real Failure</i> | |
| 20a MEDICAL CERTIFICATION | | 20b DATE OF OPERATION | | 20c CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20d AUTOPSY? | | | 20e IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET | | | CITY OR TOWN | | | COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <i>8/25/79</i> to <i>8/25/79</i> that (I) (we) last saw the deceased alive on <i>8/25/79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did/did not view the body after death. | | | | | | | | | | | | | |
| 22b SIGNATURE <i>John G Green</i> | | 22c DEGREE | | | | | | | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OF PRINT) <i>John G Green</i> | | 22e ADDRESS <i>215 Ohio Ave SALISBURY, MD.</i> | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b DATE 8/3/79 | | 23c NAME OF CEMETERY OR CREMATORIUM ORIOLE CEMETERY | | | 23d LOCATION CITY, TOWN ORIOLE, MARYLAND | | | STATE | | | |
| 24 FUNERAL DIRECTOR NAME LEVIN R. WILSON PRINCESS ANNE, MD. | | 25a DATE REC'D. BY REGISTRAR AUG 7 1979 | | | | | | | | | | 25b REGISTRAR'S SIGNATURE <i>Lillian McCready</i> | |
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